

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

■ its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12510 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2199

VS. A15ME
SM 9/60

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

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MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN It Don DO) .A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS Steels Motel							
3. NAME OF DECEASED (Type or print) Lonnie Franklin Anders				4. DATE OF DEATH Month 11 Day 10 Year 1961				5. SEX M 6. COLOR OR RACE W			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 12-16-1903 WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. AGE (In years last birthday) 57 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner 10b. KIND OF BUSINESS OR INDUSTRY Coal mining			
11. BIRTHPLACE (State or foreign country) Va.				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Jasper Anders			
14. MOTHER'S MAIDEN NAME Bertha McCann				15. WAS DECEASED EVER IN U.S. ARMED FORCES? no				16. SOCIAL SECURITY NO. 236-09-0246			
17. INFORMANT Hospital Records				18. CRUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage of Lungs 523.0 DUE TO Silicosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)				(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R.C. Dodson				EXAMINER'S NAME (Type) R.C. Dodson, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 11-10-61				22a. BURIAL, CREMATION, REMOVAL (Specify) Removal							
22b. DATE THEREOF 11-20-61				22c. NAME OF CEMETERY OR CREMATORY Galex, Virginia				22d. LOCATION (City, town, or country) Elkton, Md.			
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				24a. REC'D BY REGISTRAR NOV 22 '61				24b. REGISTRAR'S SIGNATURE C. L. F. F.			

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FOR STATE
HEALTH DEPT.

TO DIVISION OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12502											
1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT c. LENGTH OF STAY in lb 11 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE 222, PORT DEPOSIT, MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CECIL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT d. STREET ADDRESS 204B LAFFEY CIRCLE PORT DEPOSIT MD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First JOHN Middle EDWARD Last ANDERSON						4. DATE OF DEATH Month November Day 4 Year 19 61					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 August 1935		9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radioman				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy				11. BIRTHPLACE (State or foreign country) Washington State		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Anderson						14. MOTHER'S MAIDEN NAME Hazel Drew					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 7-30-54, 11-4-61						16. SOCIAL SECURITY NO. 536 32 0144					
17. INFORMANT U. S. Naval Service Record, Bainbridge, Md.						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) left tibia & fibula above ankle, Fracture right tibia & fibula & femur, Fracture right humerus, (b) Laceration left side of face & forehead, Laceration left wrist, Abrasions finger & face, Laceration right upper leg posteriorly. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 823X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Compound Fracture left tibia & fibula above ankle. Fractures Right tibia fibula & femur, right humerus. 19. WAS A UPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Station Wagon ran off of road and hit a tree. 20c. TIME OF INJURY Month, Day, Year 11-4-61 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. #222 20f. (City or town) Port Deposit, Cecil Md. (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 11-4-61 DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S SIGNATURE R. C. DODSON M.D. EXAMINER'S NAME (Type) R. C. DODSON Address (Street, city, town, or county) Rising Sun, Maryland 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal 22b. DATE THEREOF 11-6-1961 22c. NAME OF CEMETERY OR CREMATORY Fort Rosecrans National 22d. LOCATION (City, town, or country) (State) San Diego, 6, California. 23. FUNERAL DIRECTOR Lee a. Patterson & Son, ADDRESS Perryville, Md. 24a. REC'D BY REGISTRAR NOV 7 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Kline											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12514

CERTIFICATE OF DEATH

12503

1. PLACE OF DEATH a. COUNTY Gecil County		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsburgh	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS 513 Campbell St.	
3. NAME OF DECEASED (Type or print) MICHAEL J. MY BOYLE		4. DATE OF DEATH 11 27 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-90
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Ireland	
11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael J. Boyle		14. MOTHER'S MAIDEN NAME Margaret Riedy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWI		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT VA Hospital Records-Perry Point, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year the VA		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (Name of physician) attended the deceased from 7-18-46, 19 to 11-27-61, 19 and that death occurred 3:10 PM from the causes and on the date stated above.			
22a. SIGNATURE Dhia Allahverdi		22b. DATE SIGNED 11-27-61	
22c. PHYSICIAN'S NAME (Type) DHIA ALLAHVERDI, M.D.		22d. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 11/28/1961	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town or county) (State) Pittsburgh, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington L. Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR DATE NOV 30 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Henson			

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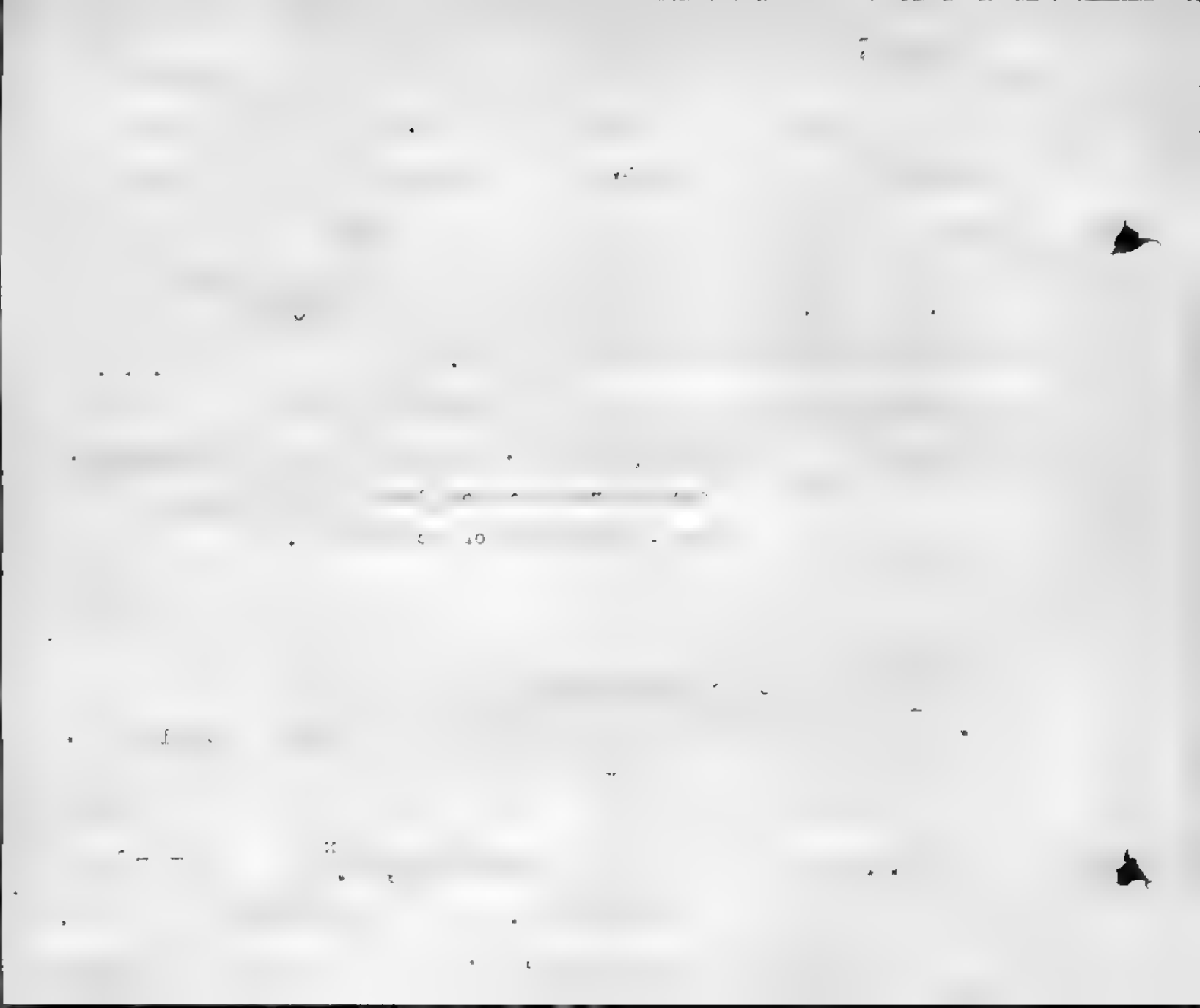
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

12515
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12501

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)		4. DATE OF DEATH		5. SEX	
First Middle Last		Month Day Year		M. W.	
Kenneth Edward Brammer		11/22/1961		M.	
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
W.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12/22/1940	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Fork Lift Operator Cable Plant		Md.		20. YES	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Glyde Brammer		Blanche Pyle		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMATION	
Yes		219 38 5959		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Fracture of both lower legs left arm and neck laceration of face and nose. DUE TO (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
		Car collided with tree			
20c. TIME OF INJURY Month Day Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.)	
11.25 p.m. 11 22 61		While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		Route 145 Elkton Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		11-23-61	
R.C. Dodson		DEPUTY MEDICAL EXAMINER			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		11/27/61		Conowingo Cem.	
23. FUNERAL DIRECTOR		24. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Thomas E. McMullen		Rising Sun, Md.		DATE NOV 27 61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

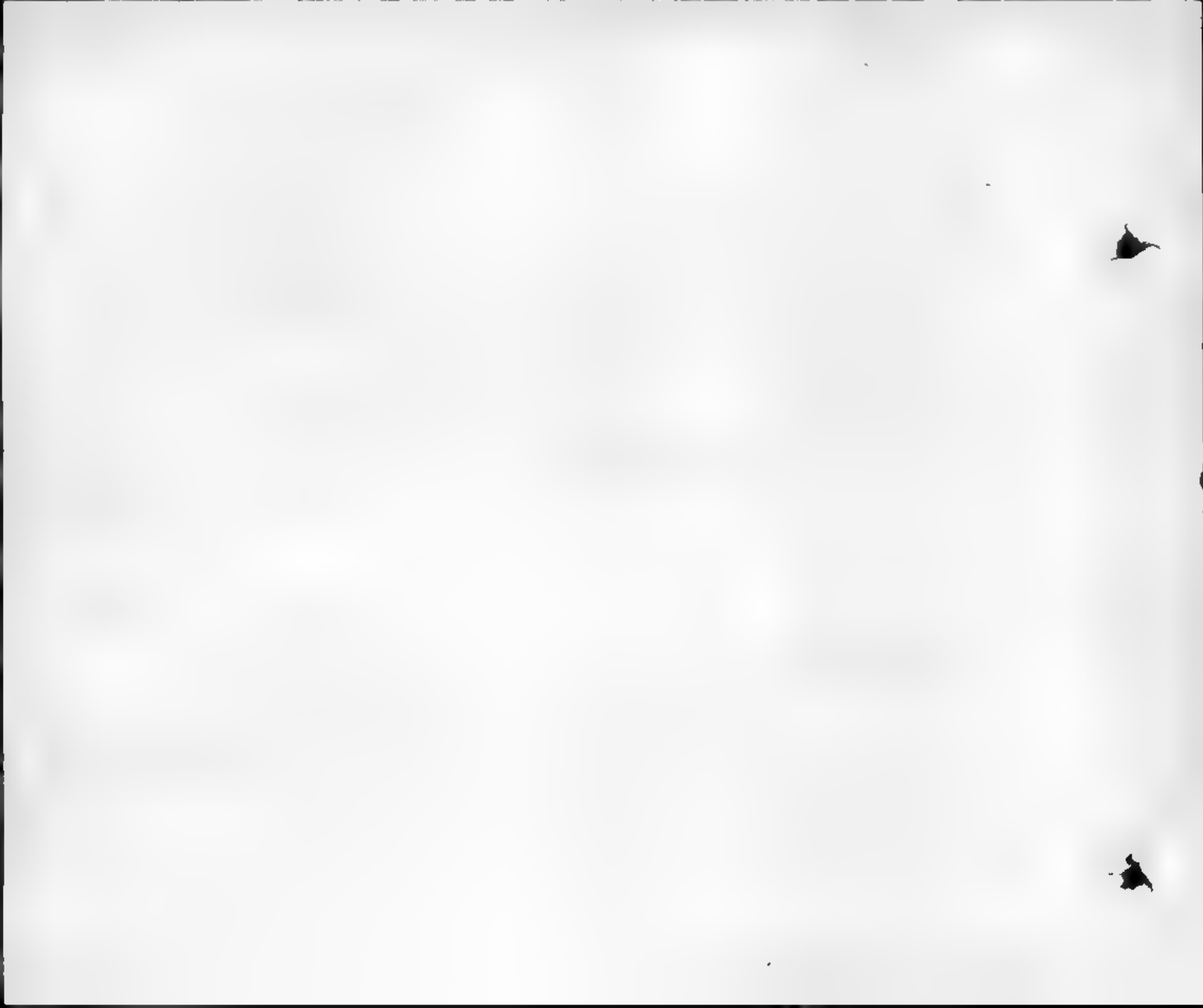
12516

VR A15 4
15M 7 61

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN TB <u>34 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital of Cecil County</u>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural R. D. 3 Elkton, Md.</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED Type or print <u>James F. Brown</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 15, 1904</u> 9. AGE (In years, last birthday) <u>56</u> yrs. IF UNDER 1 YEAR <u>12</u> Months <u>24</u> Days <u>15</u> Hours <u>15</u> Min.		4 DATE OF DEATH <u>Nov 29</u> 19 <u>61</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sty Mill Work (General)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> 11. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James H. Brown</u> 14. MOTHER'S MAIDEN NAME <u>first-unknown last-Taylor</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>813-10-0320</u> 17. INFORMANT <u>Mrs. Lucy W. Brown, R. D. 3, Elkton, Md.</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions if any which gave rise to immediate cause (a), stating the underlying cause last } DUE TO <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>12 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part III of item 18) OF CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) _____		20c. TIME OF INJURY Month Day Year <u>Dec 1960</u> 20d. INJURY OCCURRED <u>at work</u> 20e. PLACE OF INJURY Home farm _____ 20f. CITY OR TOWN _____ County _____ State _____	
21. I certify that: (1) (this hospital) attended the deceased from <u>Dec 1960</u> to <u>Nov 29, 1961</u> , that (1) (we) last saw the deceased alive on <u>Nov. 29, 1961</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph F. Lanzi</u> M.D. 22b. ADDRESS <u>500 W. Main Street, Elkton, Md.</u> 22c. PHYSICIAN'S NAME AND TYPE _____ 22d. DATE SIGNED _____		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Dec. 2, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Elkton Memorial Park</u> 23d. LOCATION (City, town or county) <u>Elkton, Maryland</u> State _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u> ADDRESS <u>Elkton, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 14 '61</u> 25b. REGISTRAR'S SIGNATURE _____ DATE _____	

MEDICAL CERTIFICATION



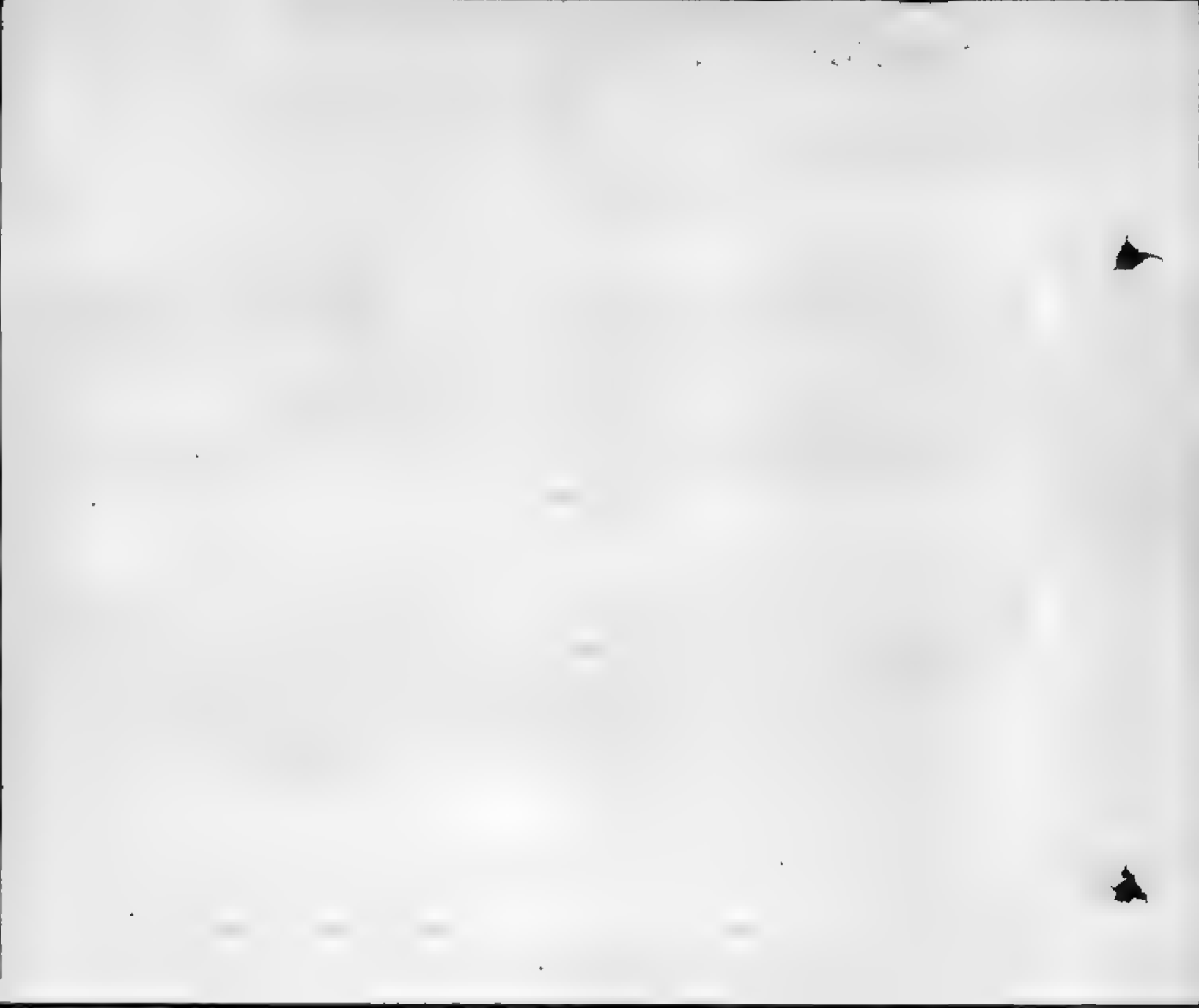
FOR STATE
HEALTH DEPT.

1. TO REPLY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. Any delay is necessary, give the funeral director Page 1, 2, and 3 in the State Register of Health. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Register of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9,60

<div> <div>12</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>12501</div> <div>12501</div> </div> <div> <div>12501</div> <div>12501</div> </div>											
<div> <div>12501</div> <div>12501</div> </div> <div> <div>12501</div> <div>12501</div> </div> <div> <div>12501</div> <div>12501</div> </div>											
1. PLACE OF DEATH a. COUNTY Cecil				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAT IN 1b 8 years			
2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland				b. COUNTY Cecil				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton			
3. NAME OF (Type or print) Vernon C Brown				4. DATE OF DEATH Month Nov. Day 7 Year 1961				5. SEX Male			
6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH April 7, 1912			
9. AGE (In years, last birthday) 49 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Vernon Brown				14. MOTHER'S MAIDEN NAME Della Anderson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes				16. SOCIAL SECURITY NO. 219-16-5804				17. INFORMANT Mrs Ruth Ann Brown, Elkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
<div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Strangulation by Hanging</div> <div>DUE TO</div> <div>(b)</div> <div>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.</div> <div>DUE TO</div> <div>(c)</div> </div>											
19. INTERVAL BETWEEN ONSET AND DEATH 10min.											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) Put rope around joint and around neck and stepped off chair											
20c. TIME OF INJURY Month Day Year ? Hour a.m. 11-7 19 61				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Elkton				20g. (County) Cecil				20h. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22. ACTUAL R.C. Dodson M.D.											
23. EXAMINER'S NAME (Type) R.C. Dodson											
24. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11-8-1961											
25. ADDRESS (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-11-61				22c. NAME OF CEMETERY OR CREMATORY North East Methodist			
22d. LOCATION (City, town, or country) North East, Maryland				22e. (State) Md.				22f. (Country) USA			
23. FUNERAL DIRECTOR Joseph R. Grant North East, Md.											
24. REC'D BY REGISTRAR NOV 10 '61											
24b. REGISTRAR'S SIGNATURE Arthur L. Grant											

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12518

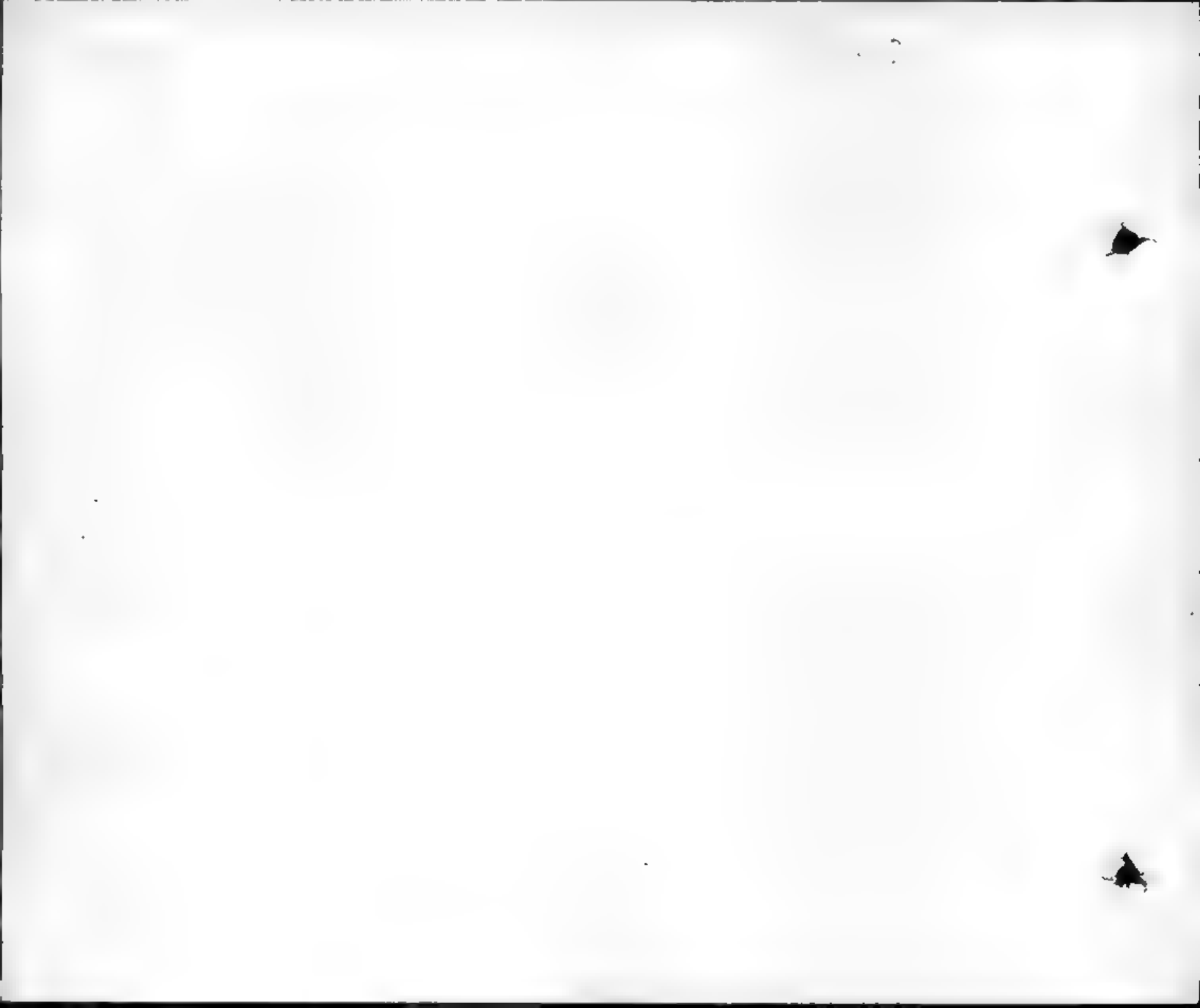
CERTIFICATE OF DEATH

Reg Dis 12500

1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN Elkton c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (if not in hospital give street address) OR INSTITUTION Elkton Hospital		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) P. O. # 1111 d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Ellis W. Allock		4 DATE OF DEATH Month Day Year Nov. 1, 1961	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 10, 1893
9 AGE (In years last birthday) 68 yrs		F UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Feeds, Maryland	
11 BIRTHPLACE (State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William W. Allock		14. MOTHER'S MAIDEN NAME Sarah Jane Allock	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) Hospital records	
17 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure Conditions (if any which gave rise to immediate cause (a), stating the underlying cause last) (b) Coronary Artery Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Pulmonary emphysema		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory street, office bldg. etc.)		20f. CITY or town: (County) (State)	
21 I certify that I attended the deceased from 10-29 1961 to 11-1-1961 that I last saw the deceased alive on 11-1-1961, and that death occurred at M. from the causes and on the date stated above ADDRESS (Street city or town, state) DATE SIGNED 123 S. 1st St. 11-3-61			
ACTUAL SIGNATURE Tillman D. Johnson M.D.		PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D. Elkton, Md.	
22a. BURIAL CREMATION REMOVAL (Specify) 11/5/61	22b. DATE THEREOF 11/5/61	22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	22d. LOCATION (City town or county) (State) Cecil County, Md.
23 FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Maryland	
24a. REC'D BY REGISTRAR DATE NOV 8 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completed by the attending physician and correctly filled in by the funeral director. After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1
M

12507

PLACE OF DEATH
a. COUNTY **Cecil** **MARYLAND**
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) **Perry Point**
c. LENGTH OF STAY IN b. **29 days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Veterans Administration Hospital**

2. USUAL RESIDENCE Where deceased lived, if institution; Residence before admission
a. STATE **District of Columbia**
b. COUNTY **Washington**
c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) **Washington**
d. STREET ADDRESS **1846 Vernon Street, N.W.**

3. NAME OF DECEASED First Middle Last
LEWIS (NMI) CARTER
Type or print

5. SEX **Male** **Negro** **WIDOWED** ☒ **NEVER MARRIED** ☐ **DIVORCED** ☐
6. COLOR OR RACE **4-8-88**

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) **Chauffeur**
10b. KIND OF BUSINESS OR INDUSTRY **Not available**
11. BIRTHPLACE County & State or foreign country **Virginia**
12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **George Carter (deceased)**
14. MOTHER'S MAIDEN NAME **Charlotte Lyle (deceased)**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) **Yes WW-I**
16. SOCIAL SECURITY NO. **Not available**
17. INFORMANT **Hospital Records, VAH, Perry Point, Md.**
Address

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
Due to **Lower nephron nephrosis, cause undetermined post-operative**
Conditions if any, which gave rise to immediate cause (b) **Right Lower Quadrant sinus tract and cellulitis of the abdominal wall**
a, stating the underlying cause last. (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

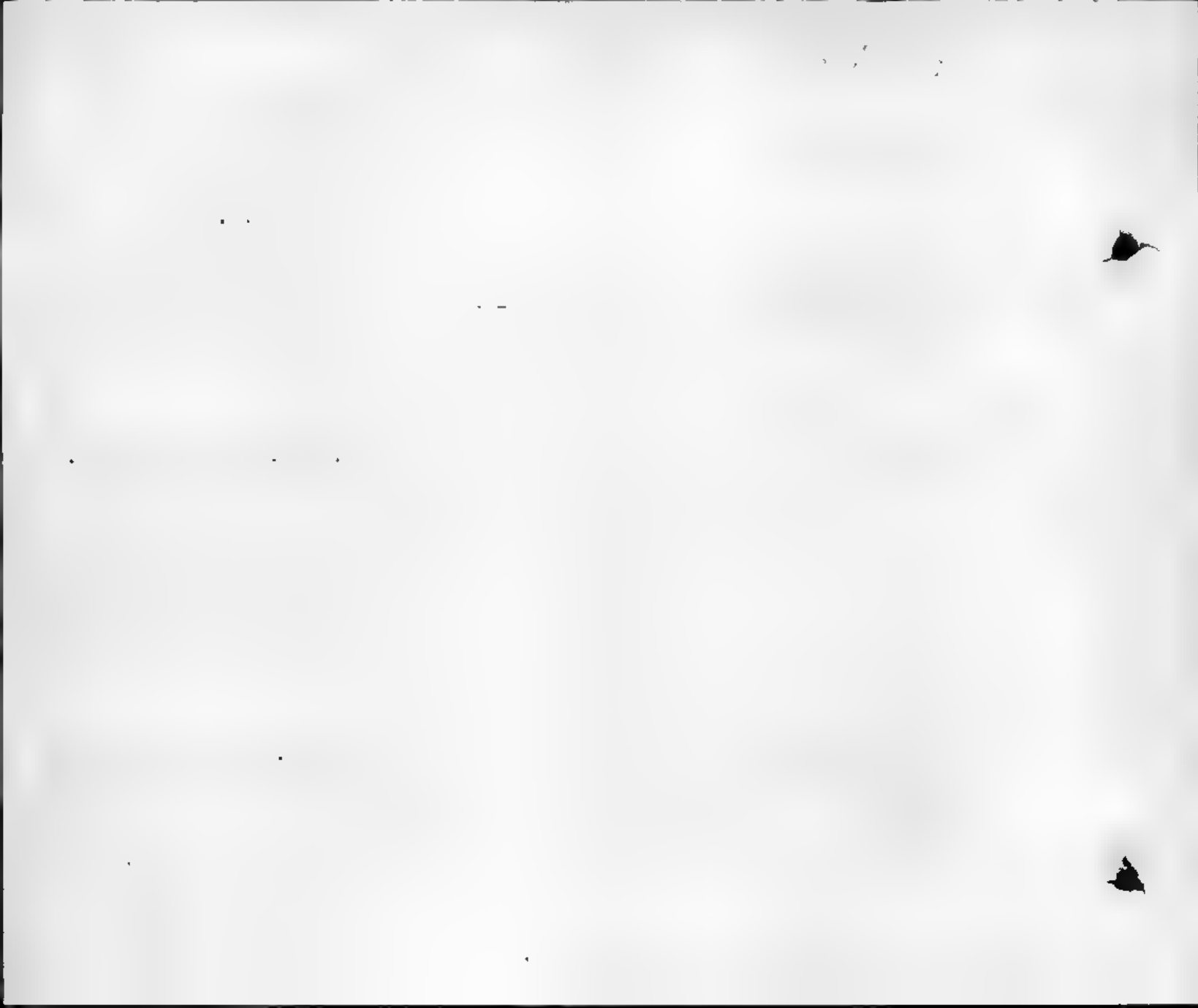
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH OF EITHER PARTY? MEDICAL EXAMINER
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year **VA 19**
Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY Home farm factory, street, office bldg., etc.
20f. City or town (County) State

21. I certify that (Name of Hospital) attended the deceased from October 23 1961 to Nov. 21, 1961 and that death occurred at 10:20 pm M. from the causes and on the date stated above

22a. SIGNATURE **Stephen A. Hegedus**
22b. PHYSICIAN'S NAME (Type) **S. A. HEGEDUS**
22c. ADDRESS **V.A. Hospital, Perry Point, Md.**

23a. BURIAL, CREMATION, REMOVAL Specify **11/24/61**
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY **Arlington National**
23d. LOCATION (City, town or county) State) **Arlington, Virginia**

24. FUNERAL DIRECTOR'S SIGNATURE **Pennell, Ton & Son, Havre de Grace, Md.**
25a. REC'D BY REGISTRAR **25b. REGISTRAR'S SIGNATURE** **Nov 30 '61**



CERTIFICATE OF DEATH

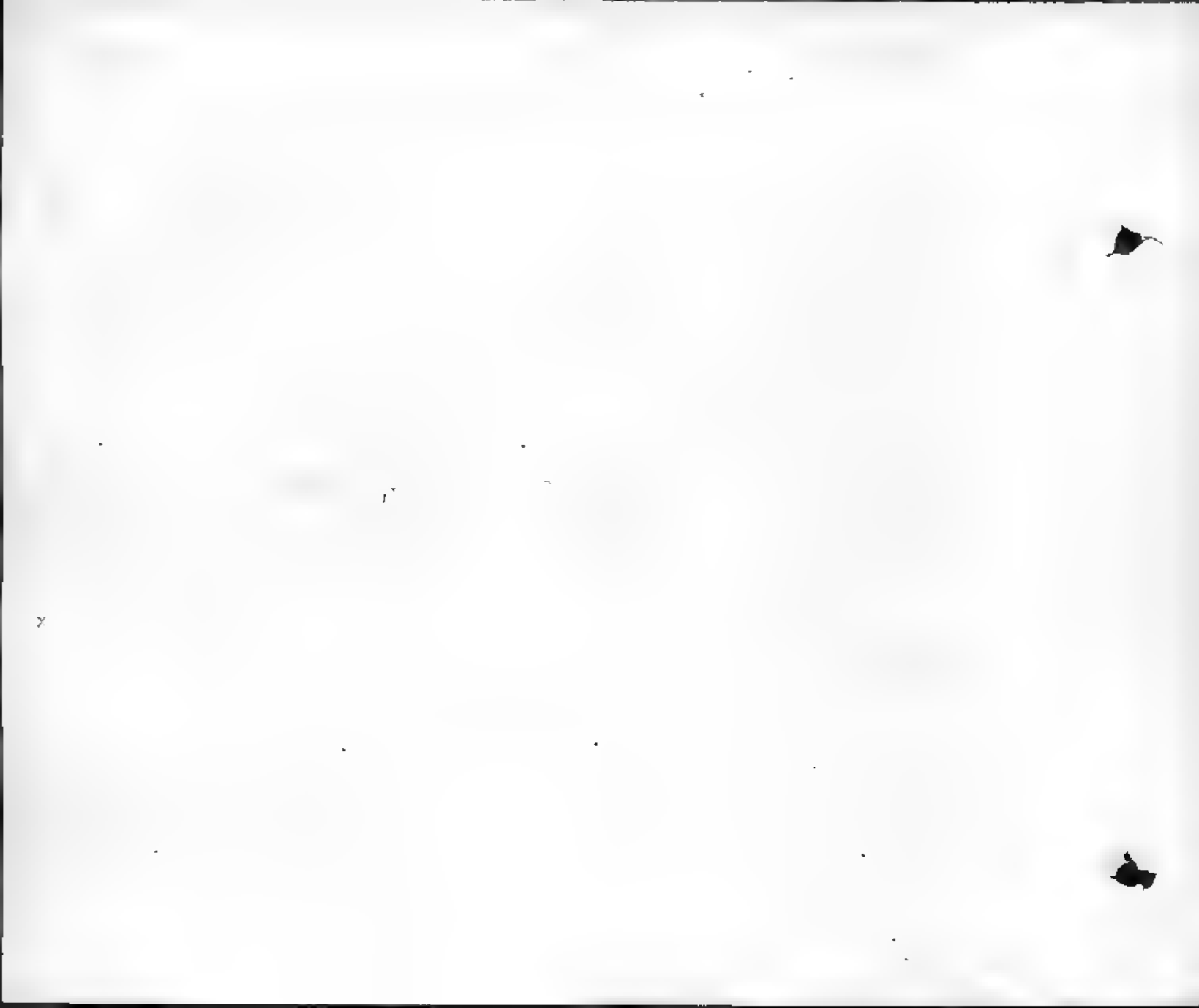
Reg. Dist. No. 12508

12520

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 12 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 1 Belle Hill	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Gerty		4. DATE OF DEATH Month Day Year Nov. 9, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1876
9. AGE (In years last birthday) 85 yrs.		10. FINDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Maryland	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME George Turner		16. MOTHER'S MAIDEN NAME Georgianna Tilly	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. INFORMANT Mrs. Marguerite Potts, Elkton, Md.	
19. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with congestive heart failure DUE TO (b) Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a Obesity INTERVAL BETWEEN ONSET AND DEATH Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 30 1961 to November 9 1961 that I last saw the deceased alive on November 8 1961 and that death occurred at M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 233 E. Main Street 11/11/61			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		M.D.	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.		Elkton Maryland	
22a. BURIAL CREMATION, REMOVAL, Specify Burial		22b. DATE THEREOF 11/12/61	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Bethel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR NOV 29 '61		24b. REGISTRAR'S SIGNATURE William S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

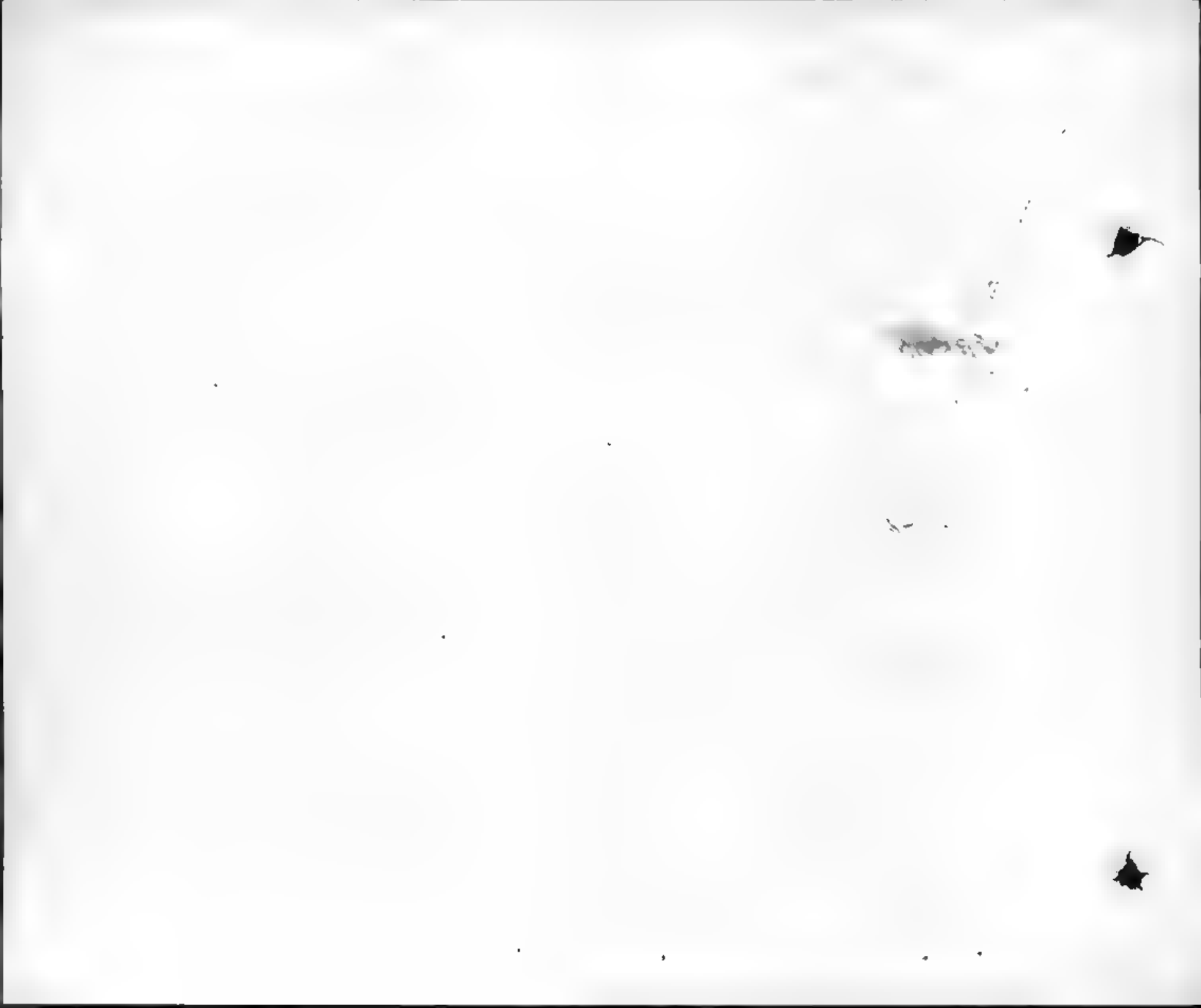


CERTIFICATE OF DEATH

Reg Dis 12509

1 PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RISING SUN</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>X RISING SUN</u>	
f. STREET ADDRESS <u>116 BUCKLEY AVENUE</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>NORVAL MILLARD COALE</u>		4 DATE OF DEATH Month Day Year <u>NOV. 20 1961</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 9, 1904</u>
9 AGE (In years last birthday) <u>57</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <u>PLASTERER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTOR</u>	
11 BIRTHPLACE (State or foreign country) <u>PHILADELPHIA, PA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>SAMUEL T. COALE</u>		14 MOTHER'S MAIDEN NAME <u>CLARA HINDMAN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>216-07-8801</u>	
17 INFORMANT <u>OLIVE COALE, RISING SUN, MD</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> Conditions (b) <u>hypertension</u> gave rise to immediate cause (a), stating the underlying cause last (c) <u>alcoholism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 wks.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home (farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from <u>11/2</u> 19 <u>61</u> , to <u>11/20</u> 19 <u>61</u> , that I last saw the deceased alive on <u>11/20</u> 19 <u>61</u> , and that death occurred at <u>11</u> M from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor Jr</u> MD		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr MD</u>		DATE SIGNED <u>11/21/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cemetery</u>	22d. LOCATION (City, town or county) (State) <u>Rising Sun, Md.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M. Reed, Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR <u>11/24/61</u>	
ADDRESS <u>Rising Sun, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Curt S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be completed by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial, cremation, or removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

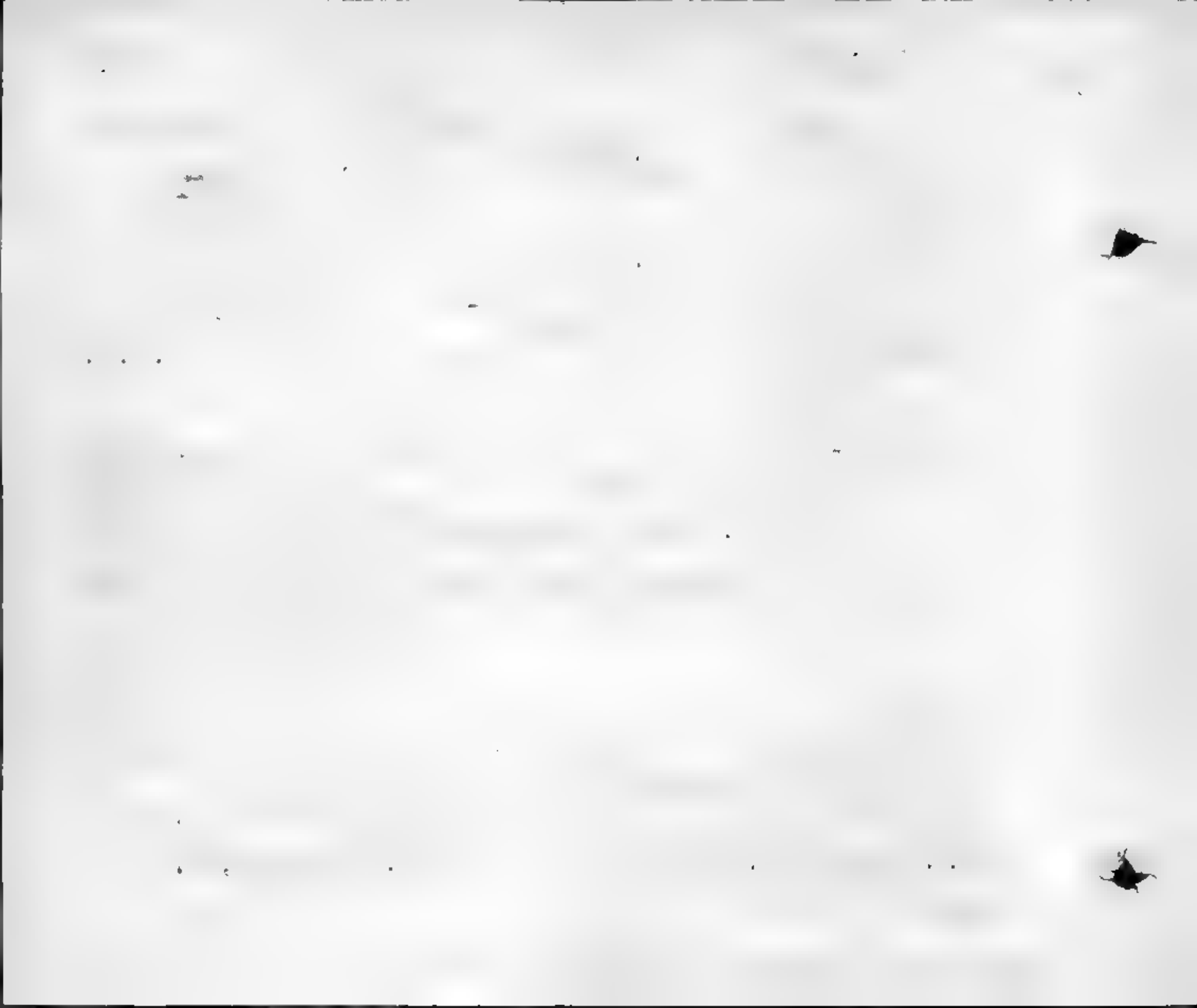
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12522

CERTIFICATE OF DEATH

12510

1 PLACE OF DEATH a. COUNTY Cecil		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Queen Annes	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graysonville,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS None	
3 NAME OF DECEASED (Type or print) Thomas H. Collier		4 DATE OF DEATH Nov 4 19 61	
5 SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 5-20-76	
9 AGE In years (If UNDER 1 YEAR, last birthday) 85 yrs.		10. MONTHS 5 DAYS 14	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Thomas Henry Collier		14. MOTHER'S MAIDEN NAME Rachel Horsey	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give word details of service) Yes SAW - WW I		16 SOCIAL SECURITY NO MOIE -	
17 INFORMANT VA Hospital Records - Perry Point, Maryland		INTERVAL BETWEEN ONSET AND DEATH 4-7 Days	
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART a. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 b. DUE TO c. DUE TO Chronic Brain Syndrome		b. CHr. Congestive Heart Failure Arteriosclerotic Heart Disease	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF EITHER NOT BY MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part c or Part d of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.)		20f City or town County State	
21 I certify that (this hospital) attended the deceased from 7-14-60 to 11-4-61, 1961, and that death occurred at 5:15AM from the causes and on the date stated above.			
22a SIGNATURE A.L. Mooney		22b. DATE SIGNED 11/4/61	
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, Clin. Pathologist		22d. ADDRESS VAH., Perry Point, Md.	
23a BURIAL, CREMATION, REMOVAL Specify Removal		23b. DATE THEREOF 11/4/61	
23c. NAME OF CEMETERY OR CREMATORY Stonewall		23d. LOCATION (City, town or county) Stonewall Md	
24 FUNERAL DIRECTOR'S SIGNATURE H. Law and Brother of Baiter Ben Carterwell		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE C. H. H. H. H.	



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

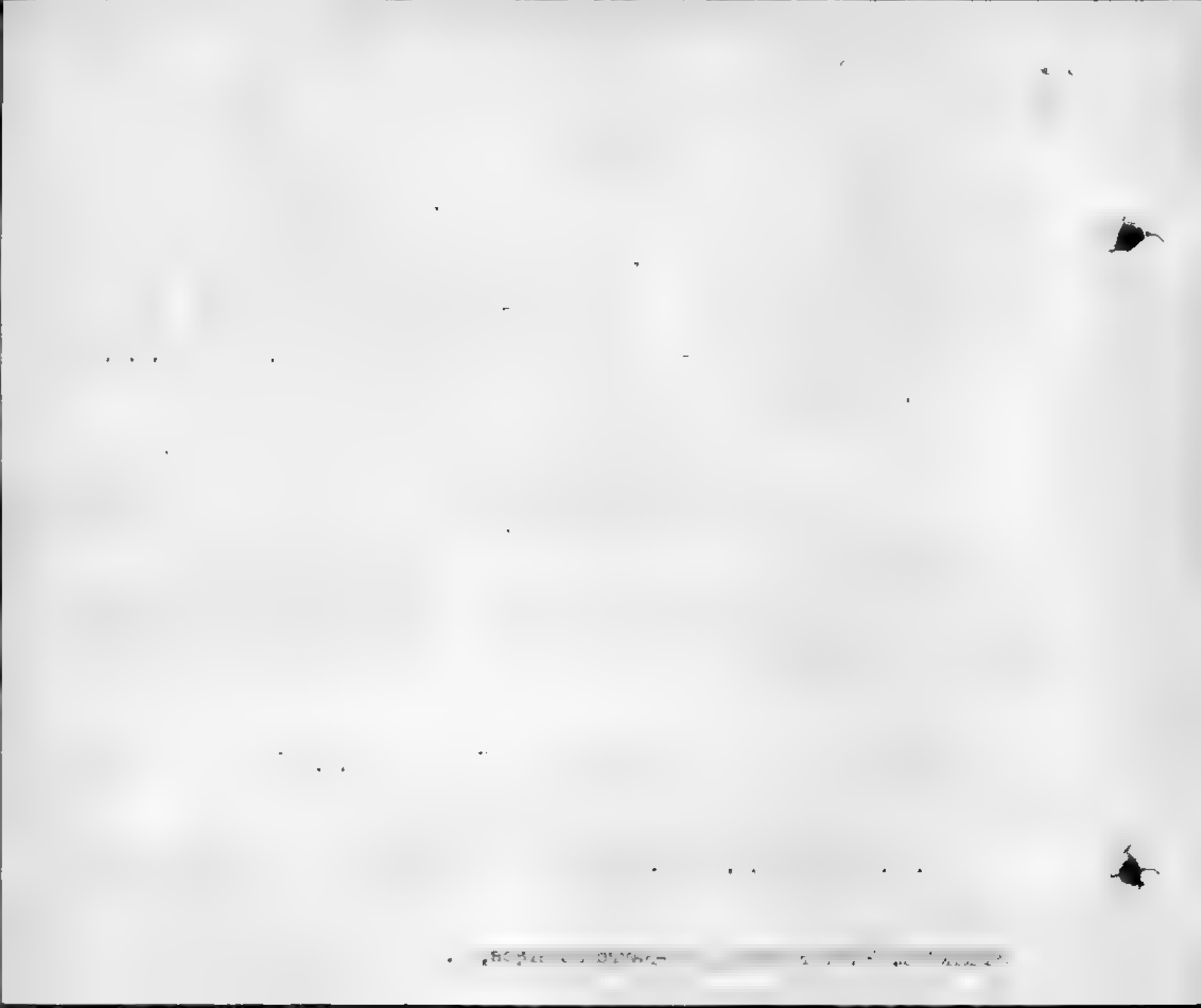
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12523
12511

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN TB 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital				2. USUAL RESIDENCE Where deceased lived, if not in US. Residence before admission. a. STATE New Jersey b. COUNTY Gloucester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clayton d. STREET ADDRESS 334 S. Delsey Drive			
3. NAME OF DECEASED Type or print First Middle Last John E. Collins				4. DATE OF DEATH Month Day Year Nov 4 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-13-99	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weaver		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Collins				14. MOTHER'S MAIDEN NAME Elizabeth Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown. If yes, give year or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 142 09 6692			
17. INFORMANT VA Hospital Records - Perry Point, Maryland				Address			
18. CAUSE OF DEATH (Enter only one cause per line for a, b and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 5 1 1 DUE TO Bronchopneumonia, bilateral Pulmonary Emphysema, severe Conditions if any which gave rise to immediate cause (a), stating the underlying cause as: DUE TO c				INTERVAL BETWEEN ONSET AND DEATH 4-6 days Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a Chronic Gastric Ulcer - 2 years				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item 18 20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town (County) (State)							
21. I certify that 30 (this hospital) attended the deceased from 10-23 , 19 61 to 11-4 , 19 61 , and that death occurred at 3:30 P.m. from the causes and on the date stated above.							
22a. SIGNATURE A. L. Mooney 22c. PHYSICIAN'S NAME Type A. L. MOONEY, M.D. Pathologist Asst. Clinical				22b. DATE SIGNED 11 4 61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL CREMATION REMOVAL Specify Removal 23b. DATE THEREOF 11/6/61 23c. NAME OF CEMETERY OR CREMATORY Beverly National 23d. LOCATION (City, town or county) (State) Beverly, New Jersey				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur L. Hines			
24. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON FUNERAL HOME - Havre De Grace, Md.				DATE NOV 9 '61			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

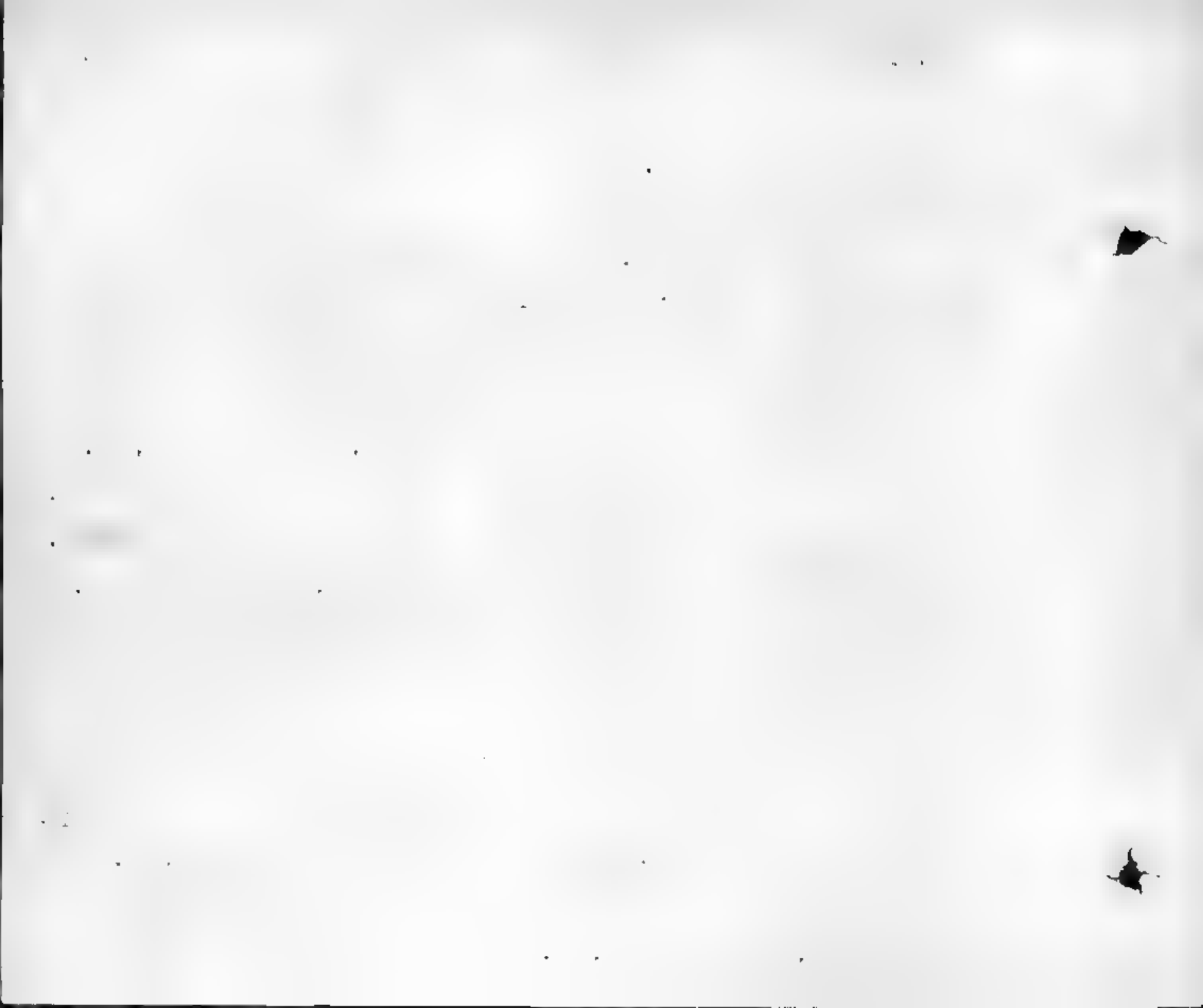
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12524

12512

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (if outside corporate limits. write RURAL and give nearest town, Perry Point		c. CITY OR TOWN (if outside corporate limits. write RURAL and give nearest town Liberty Grove	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address Veterans Administration Hospital		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) WILLIAM F. LCKARD		4. DATE OF DEATH November 16 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-4-17	
9. AGE (in years last birthday) 44		10. UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Eckard		14. MOTHER'S MAIDEN NAME Minnie Snyder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO 217-03-1164	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per part a, b, and c.)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a. Acute pulmonary edema, massive		5-10 min.	
b. Acute congestive heart failure		5-10 min.	
c. Ulcerative bacterial endocarditis, aortic valve		6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING] OR CONTRIBUTING CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part a Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home farm factory street office bldg etc		20f. City or town County State	
21. I certify that XXXXXX attended the deceased from May 1, 1961, to November 16, 1961, and that death occurred at 3:00 PM on the causes and on the date stated above		22a. SIGNATURE A. L. MOONEY	
22b. PHYSICIAN'S NAME Type A. L. MOONEY		22c. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/20/1961	
23c. NAME OF CEMETERY OR CREMATORY New Bridge		23d. LOCATION City, town or county Harrisville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SMI
SM 9,60

12525

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

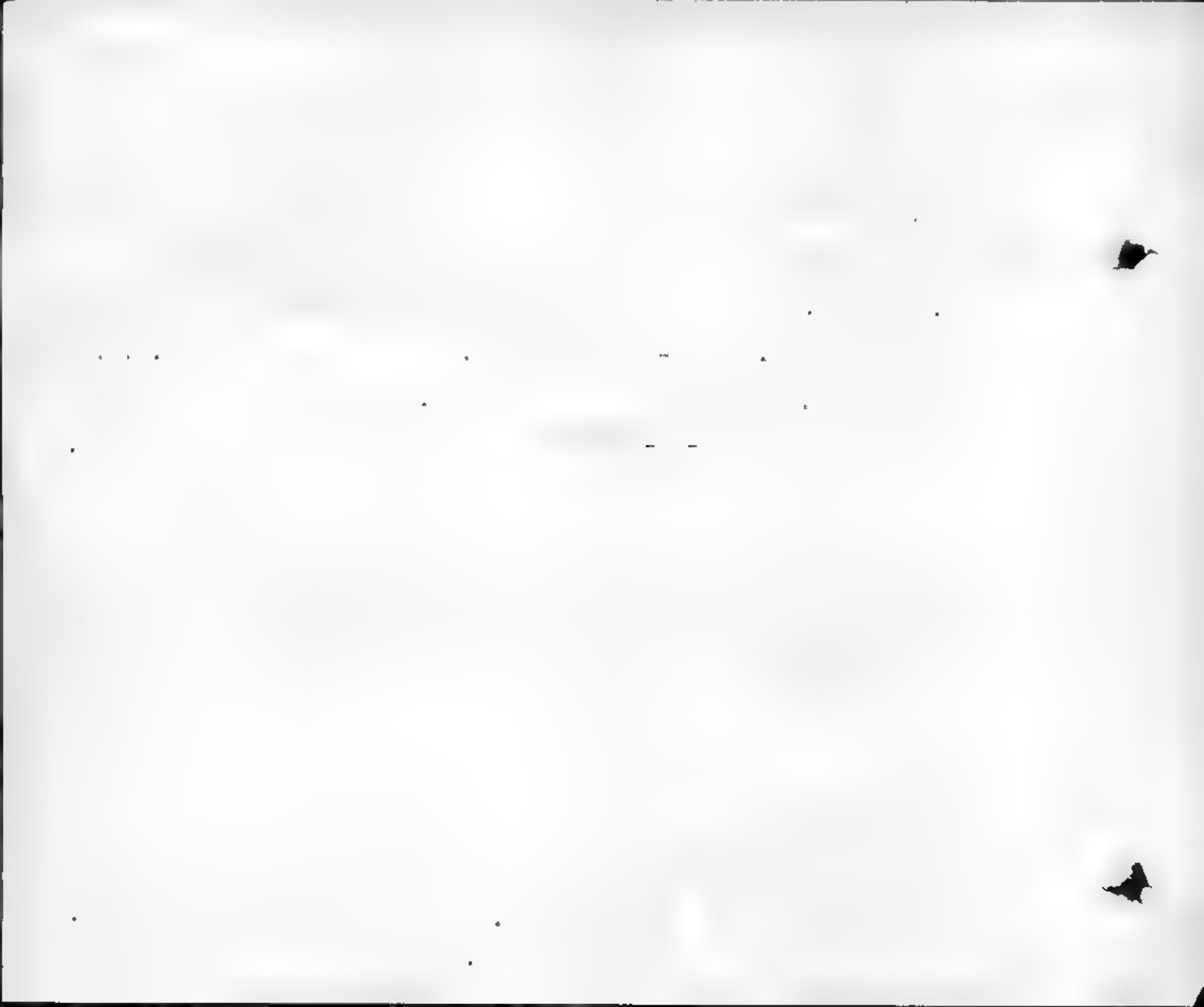
12513

1. PLACE OF DEATH a. COUNTY <u>Cecil</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Libt. D</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Libt. D Hospital D.C.A.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>W</u> Last <u>Foreacre</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Foreacre</u>		14. MOTHER'S MAIDEN NAME <u>unknown Goodrow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Mary J. Foreacre, North 2 St. Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u>		DUE TO (b) <u>Acute Coronary</u>	
DUE TO (c) <u>420.1</u>		DUE TO (d) <u>420.1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>8 a.m. 11-8 1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R.C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-12-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town or country) (State) <u>North East (Md.)</u>	
23. FUNERAL DIRECTOR <u>Joseph R. Grant</u>		24a. REC'D BY REGISTRAR <u>NOV 10 '61</u>	
ADDRESS <u>Seaboard, North East, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	



12520
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 12511

1 PLACE OF DEATH a. COUNTY CECIL MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MD. b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON				c. LENGTH OF STAY IN TB 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) UNION HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN,			
f. STREET ADDRESS				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last ALICE MATILDA GARVIN				4 DATE OF DEATH Month Day Year 11/ 8/ 1961			
5 SEX F.		6 COLOR OR RACE W.		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 1/10/1885	
9 AGE (In years last birthday yrs) 76		10 IF UNDER 1 YEAR Months Days Hours Min		11 BIRTHPLACE (State or foreign country) MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired DRESSMAKER RET.				10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED			
13 FATHER'S NAME BENJAMINE B. GARVIN				14 MOTHER'S MAIDEN NAME SUSAN R. FERGUSON			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service) NO				16 SOCIAL SECURITY NO 212-20-8320A			
17 INFORMANT Miss ANNA GARVIN				Address RISING SUN, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary heart failure							
DUE TO (b) Myocardial infarction							
DUE TO (c) Arteriosclerotic heart disease							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month Day Year Hour o m p.m. 19				20d INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from 11-25 1961 to 11-8 1961 that (I) (we) last saw the deceased alive on 11-7 1961 and that death occurred at 10AM from the causes and on the date stated above							
22a SIGNATURE Williford Eppes				22b DATE SIGNED			
22c PHYSICIAN'S NAME Williford Eppes, M.D.				22d ADDRESS Hillsider Dallas Rds Newark, Del			
23a BURIAL OR CREMATION REMOVAL (Specify) Burial				23b DATE THEREOF 11/11/1961			
23c NAME OF CEMETERY OR CREMATORY BROOKVIEW CEM.				23d LOCATION City town or county RISING SUN State MD.			
24 MEDICAL DIRECTOR'S SIGNATURE Thomas E. McMiller				25a REC'D BY REGISTRAR NOV 13 '61			
25b REGISTRAR'S SIGNATURE Arthur L. Hines							



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

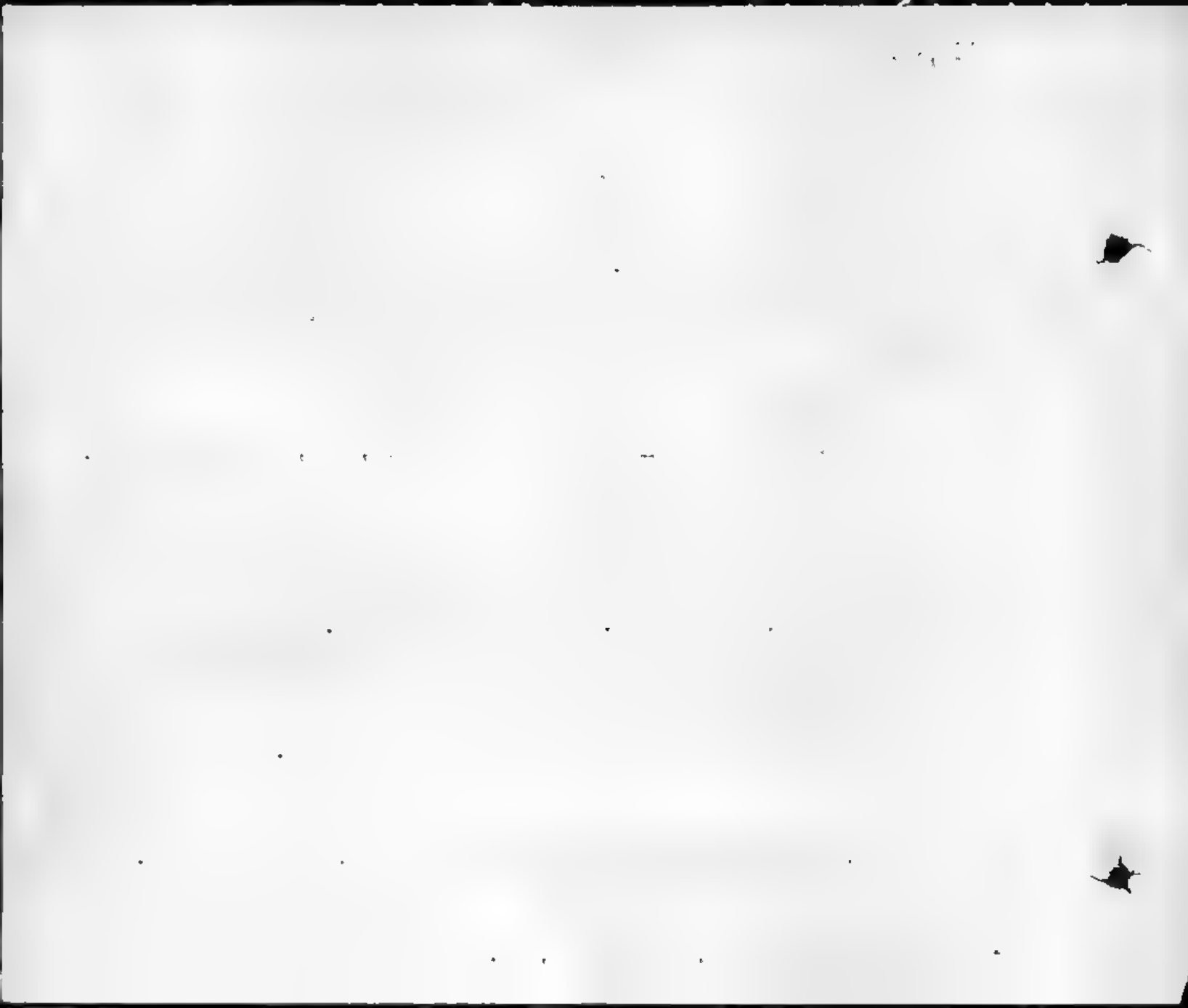
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12527

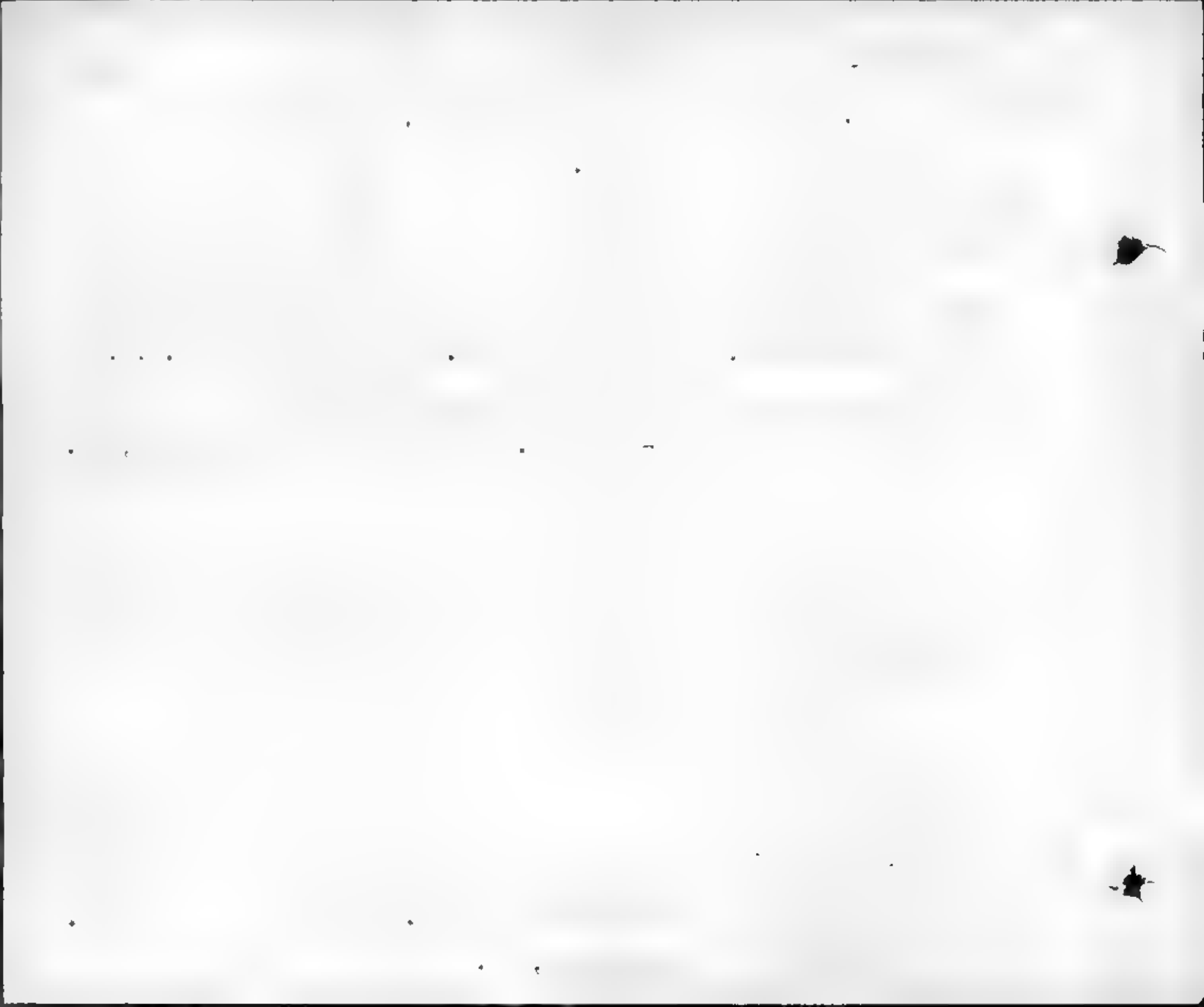
12515

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if instit or Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) JAMES L. CORRELL		4. DATE OF DEATH November 20 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-11-90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
13. FATHER'S NAME Joseph Gorrell		14. MOTHER'S MAIDEN NAME Evelyn Nesbitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO 212-12-4104	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		18. CRUISE OF DEATH (Enter only one cause per line for a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic heart disease with myocardial infarction Conditions, if any, which gave rise to immediate cause (b) 420.0 (c), stating the underlying cause last DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Arteriosclerosis, generalized. Gangrene, right foot. Chronic		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or Part III)	
20c. TIME OF INJURY Month, Day, Year VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) State	
21. I certify that JAMES L. CORRELL attended the deceased from March 31, 1960, to Nov. 20, 1961, and that death occurred at 1:45 pm on the causes and on the date stated above.		22a. SIGNATURE S. Goldgraben	
22b. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, Chief, Medical Service, VAH, Perry Point, Md.		22c. ADDRESS	
23a. BURIAL CREMATION REMOVAL Specify Burial		23b. DATE THEREOF 11/23/1961	
23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery		23d. LOCATION (City, town or county) Calver, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ralph Reed		25a. RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
25c. DATE NOV 24 '61		25d. SIGNATURE Arthur S. Hanna	



12510

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4



1
FOR STATE
HEALTH DEPT.

TO SECURTY MEDICAL EXAMINER This certificate should be executed within 24 hours after death. If any delay is necessary, place "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Ch. of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file as TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9 60

12529
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12517

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural North East		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural North East	
c. LENGTH OF STAY in lb Lifetime		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George W. Hamilton		4. DATE OF DEATH November 3 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-16-1878
9. AGE in years 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor and High School Teacher		11. BIRTHPLACE State or foreign country Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME J. Wesley Hamilton	
14. MOTHER'S MAIDEN NAME Ann Maria Mullen		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 221-03-7666		17. INFORMANT G. Page Hamilton	
18. CRUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE a. 420.1 DUE TO Acute Coronary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b. Arterio Sclerotic c. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 min Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 11-4-1961	
NAME (Type) R.C. Dodson		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL Specify Burial		22b. DATE THEREOF 11-6-1961	
22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City town or county) North East Cecil Co, Md	
23. FUNERAL DIRECTOR Joseph R Grant		24a. REC'D BY REGISTRAR NOV 9 '61	
ADDRESS North East Md		24b. REGISTRAR'S SIGNATURE J. S. Grant	



may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 1 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1344 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12530

CERTIFICATE OF DEATH

Reg. Dist. No. 12518

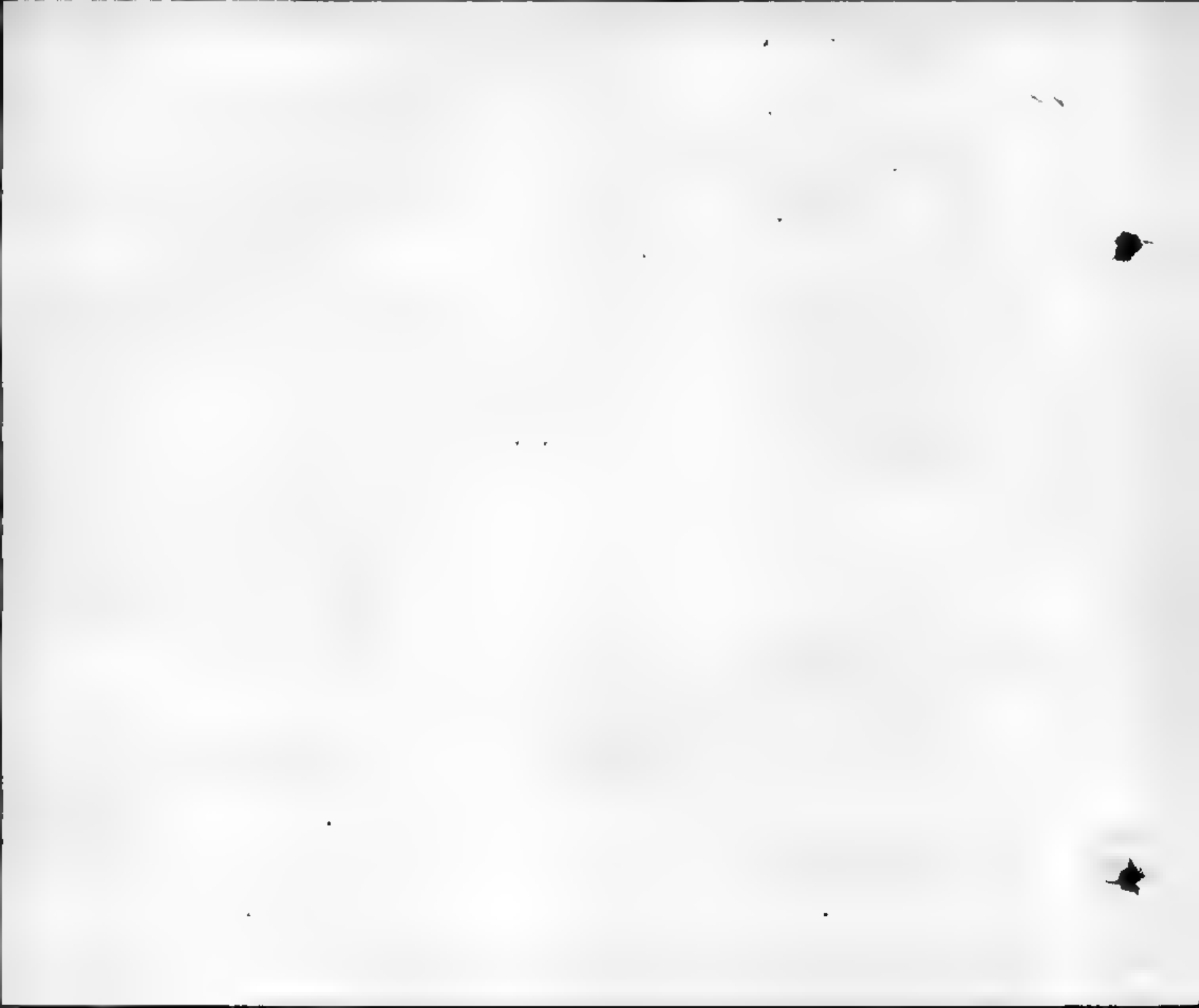
1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Delaware b. COUNTY New Castle ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 46 X 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. STREET ADDRESS 1344 Reed Street	
3 NAME OF DECEASED (Type or print) First James Middle A. Last Howell		4 DATE OF DEATH Nov. 25, 1961 19	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 26, 1902
9 AGE (In years last birthday) yrs 59		FUNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Delaware		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No record		14. MOTHER'S MAIDEN NAME No record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WW 2		16 SOCIAL SECURITY NO. 222-09-4315	
17 INFORMANT A.W. Dowell		Address Christiana, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) Anteroseptal coronary artery thrombosis (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 24 hours unk unk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTED TO CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-25, 1961, to 11-25, 1961, that I last saw the deceased alive on 11-25, 1961, and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Williford Epps		ADDRESS (Street, city or town, state) Dallam Rd. 11/27/61	
PHYSICIAN'S NAME (Type) Williford Epps		Newark, Delaware	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29, 1961	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cem.		22d. LOCATION (City, town, or county) (State) Bethel, Md.	
23 FUNERAL DIRECTOR'S SIGNATURE K. T. Jones		ADDRESS Newark, Del.	
24a. REC'D BY REGISTRAR DATE DEC 5 '61		24b. REGISTRAR'S SIGNATURE	

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MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4
may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation or removal and no other event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18											
12531 item 9 Film G302 12/18/61 iwk											
CERTIFICATE OF DEATH											
Reg. Dist. No. 12519											
1. PLACE OF DEATH a. COUNTY <u>Cecil</u>				2. USUAL RESIDENCE Where deceased lived If institution Residence before admission a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN TB <u>14 d</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>1 RD #1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>F</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>23</u> Year <u>1961</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-10</u>		9. AGE (in years last birthday) <u>51</u> yrs		F UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Oak Grove, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lucius Kelley</u>				14. MOTHER'S MAIDEN NAME <u>Maude Towers</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>George B Johnson</u>				Address <u>RD 9 Elkton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u>											
175.0 DUE TO (b) <u>Metastatic carcinoma</u>											
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Carcinoma, ovary</u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I											
<u>None</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month <u>9</u> Day <u>9</u> Year <u>1961</u> Hour <u>a</u> m <u>p</u> m				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg, etc.)		20f. (City or town)		(County, (State))	
21. I certify that I attended the deceased from <u>March</u> , 1961, to <u>11-23</u> , 1961, that I last saw the deceased alive on <u>11-23</u> , 1961, and that death occurred at <u>1:32 PM</u> , from the causes and on the date stated above.											
ADDRESS (Street, city or town, state) <u>1735 Sunsetly Ave</u> DATE SIGNED <u>11-23-61</u>											
ACTUAL SIGNATURE <u>Tillman D Johnson</u> M.D.											
PHYSICIAN'S NAME (Type) <u>Tillman D Johnson</u> M.D. <u>Elkton Md</u>											
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-27-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>WILMINGTON, DEL.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Harrington - Wilms, Del.</u>						24a. REC'D BY REGISTRAR DATE <u>NOV 29 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Hume</u>			



Herbert M. Livingston
c/o Marshall N. Johnson & Son,
General Directors
819 Washington St.
Wilmington, Del.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be filed in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

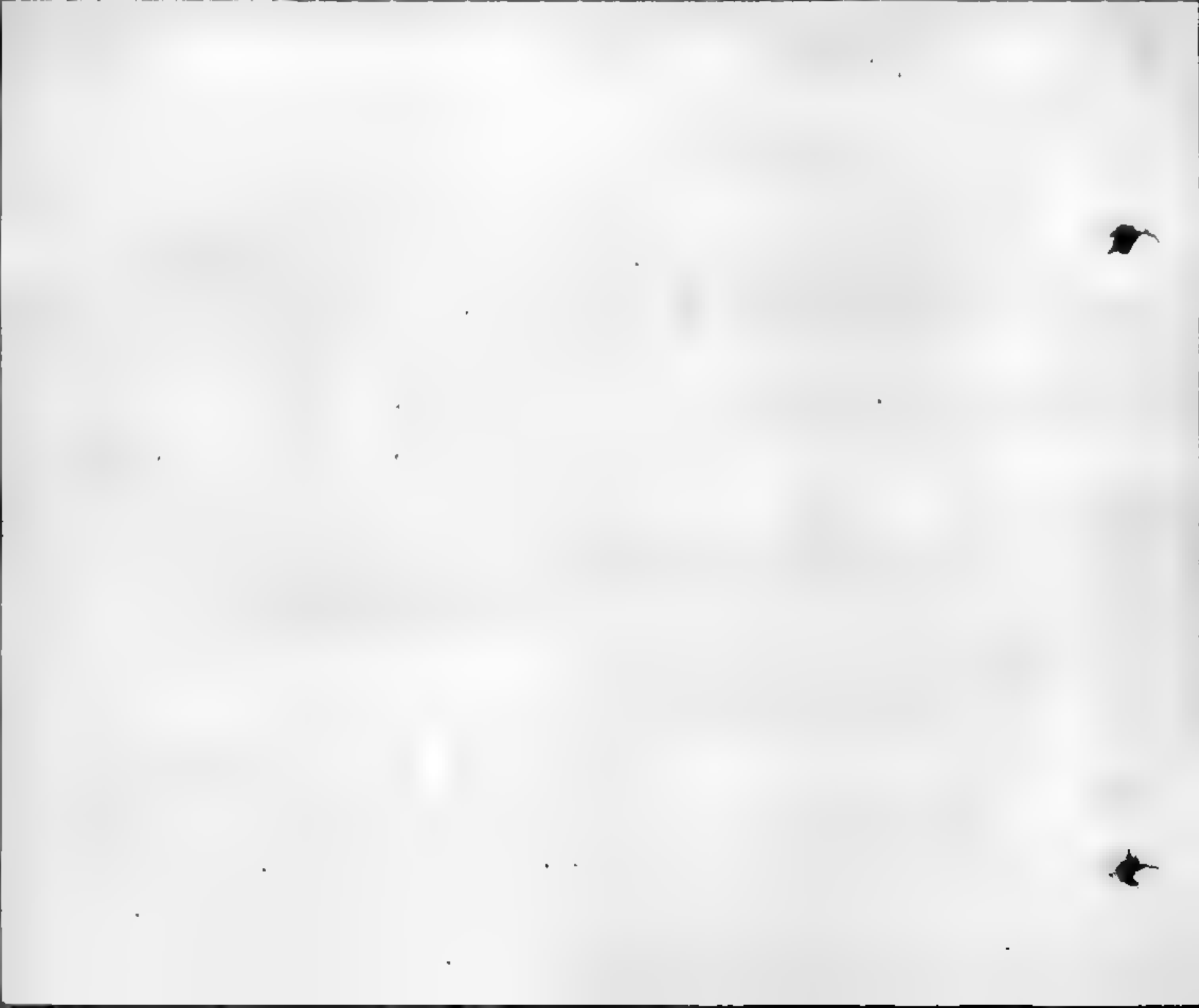
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12532

CERTIFICATE OF DEATH

12520

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE Where deceased lived if institutions Residence before admission a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN Port Deposit, Rural		c. LENGTH OF STAY Life		c. CITY OR TOWN Port Deposit, Rural	
d. NAME OF HOSPITAL OR INSTITUTION Cokesbury		d. STREET ADDRESS Cokesbury		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna B. Kell		4. DATE OF DEATH Nov. 19, 1961		5. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS. 77 yrs Months 77 Days 77 Hours 77 Min 77)	
6. SEX Female		7. COLOR OR RACE Colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH May 23, 1884		10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired House Wife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. FATHER'S NAME John T. Brown		12. CITIZEN OF WHAT COUNTRY? USA		13. MOTHER'S MAIDEN NAME Mary E. Hawkins	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		15. SOCIAL SECURITY NO Alice Jones, Port Deposit, Md.		16. INFORMANT Rural	
17. CAUSE OF DEATH Enter only one cause per line for a, b, and c PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a 3. 4X Cerebral Aneurysm Arteriosclerotic Conditions if any which gave rise to immediate cause (a), stating the underlying cause last b c DUE TO DUE TO		18. INTERVAL BETWEEN ONSET AND DEATH 44 yrs - 7 yrs -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF EITHER NOT BY MEDICAL EXAMINER		20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part or Part of item b)		20c. TIME OF INJURY Month Day Year Hour m p.m. 19	
20d. INJURY OCCURRED Where Not Where at work at work		20e. PLACE OF INJURY Home farm factory street office bldg etc		20f. City or town County State	
21. I certify that (I) (If s hospital) attended the deceased from July 1955 to Nov-18-61 that (I) (we) last saw the deceased a ve on Nov-18 1961 and that death occurred at 12 AM from the causes and on the date stated above.		22a. SIGNATURE Clarence I. Benson		22b. ADDRESS Port Deposit, Md.	
22c. PHYSICIAN'S NAME Type Clarence I. Benson, M.D.		22d. ADDRESS Port Deposit, Md.		22e. DATE SIGNED Nov-20-61	
23a. BURIAL, CREMATION, DATE THEREOF Buried 11-22-1961		23b. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery		23c. LOCATION City town or county, State, Port Deposit, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Leea. Patterson, Son,		24a. ADDRESS Perryville, Md.		24b. REC'D BY REG. STRAR Nov 24 '61	
24c. REG. STRAR'S SIGNATURE L. E. Howard		24d. DATE Nov 24 '61		24e. SIGNATURE L. E. Howard	

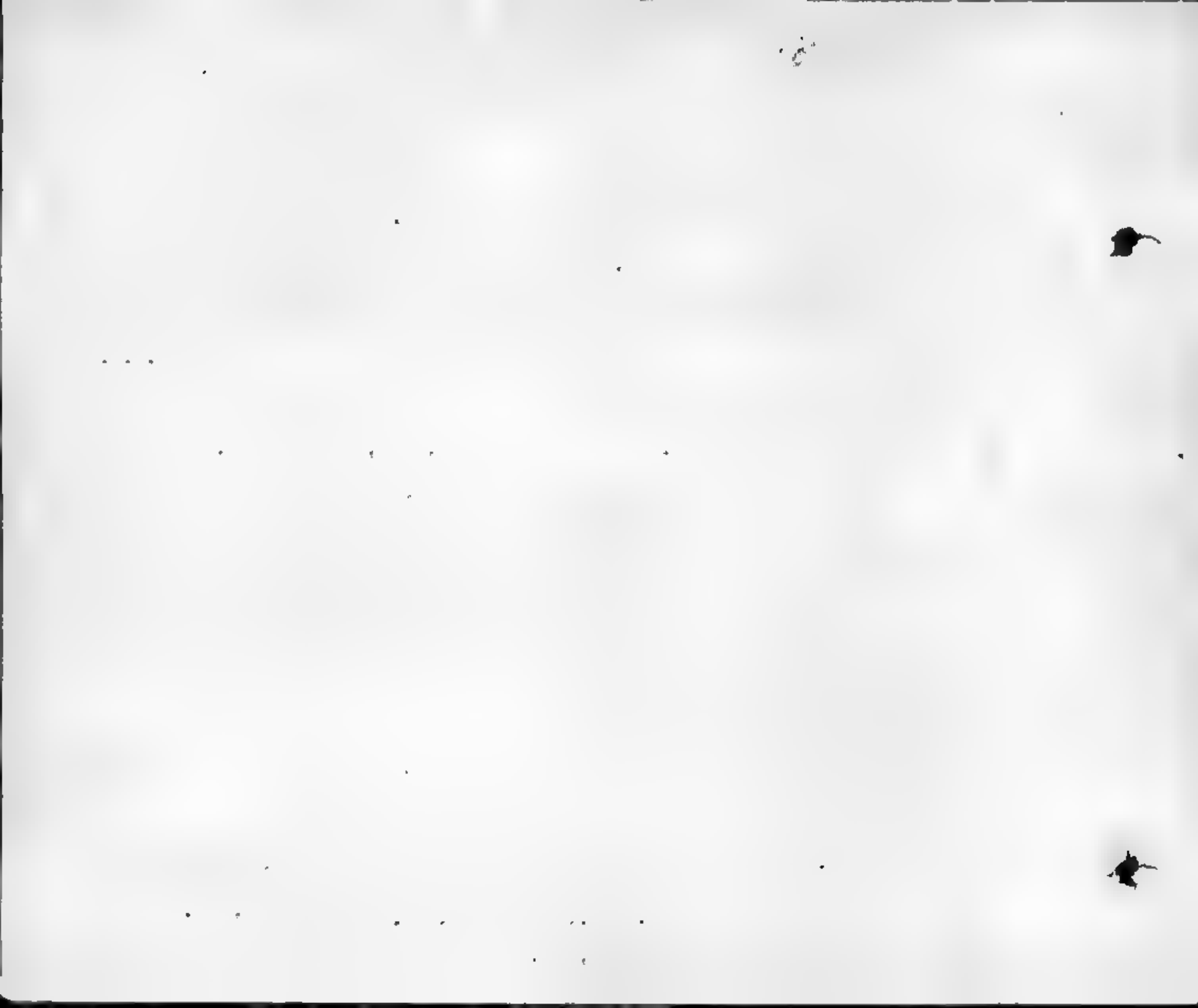


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
SM 7-61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12533 CERTIFICATE OF DEATH 12521

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY (in days) 146 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 104 N. Cresson Street	
3. NAME OF DECEASED Type or print BERNARD M. LACHNER 4. DATE OF DEATH Month November Day 23 Year 1961		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 2/12/99 9. AGE in years 62 yrs. F UNDER 1 YEAR IF UNDER 24 HRS last birthday Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY --- 11. BIRTHPLACE County & State of foreign country Maryland 12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Jacob Lachner (deceased) 14. MOTHER'S M.A.D.E.N. NAME Annie Cylander (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWI 16. SOCIAL SECURITY NO Unk. 17. INFORMANT Address VA Records, VAH, Perry Point, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART a. DEATH WAS CAUSED BY IMMEDIATE CAUSE a. Bronchopneumonia, bilateral, unresolved b. Arteriosclerotic heart disease c. unknown PART b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 18a. Arteriosclerosis generalized severe	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1c. Part 1d. of item 18) 20c. TIME OF INJURY Month Day Year Hour a.m. p.m. VA 19 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home farm factory street office bldg. etc.) 20f. (City or town) 20g. County 20h. State		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that J. L. Garey attended the deceased from 6/30 , 19 61 to 11/23 , 19 61 and that death occurred at 9:15 PM from the causes and on the date stated above. 22a. SIGNATURE J. L. Garey M.D. 22b. PHYSICIAN'S NAME TYPE J. L. GAREY, Clinical Pathologist 22c. ADDRESS VAH, Perry Point, Maryland		22d. DATE SIGNED 11/24/61	
23a. BURIAL, CREMATION, REMOVAL, SPECIFY Burial 23b. DATE THEREOF 11/28/1961 23c. NAME OF CEMETERY OR CREMATORY Natl. Cem., Baltimore, Md. 23d. LOCATION City, town or county Baltimore, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Benjamin A. Han ADDRESS Havre de Grace, Md. 25. REC'D BY REGISTRAR NOV 30 '61 25b. REGISTRAR'S SIGNATURE	



may be returned by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

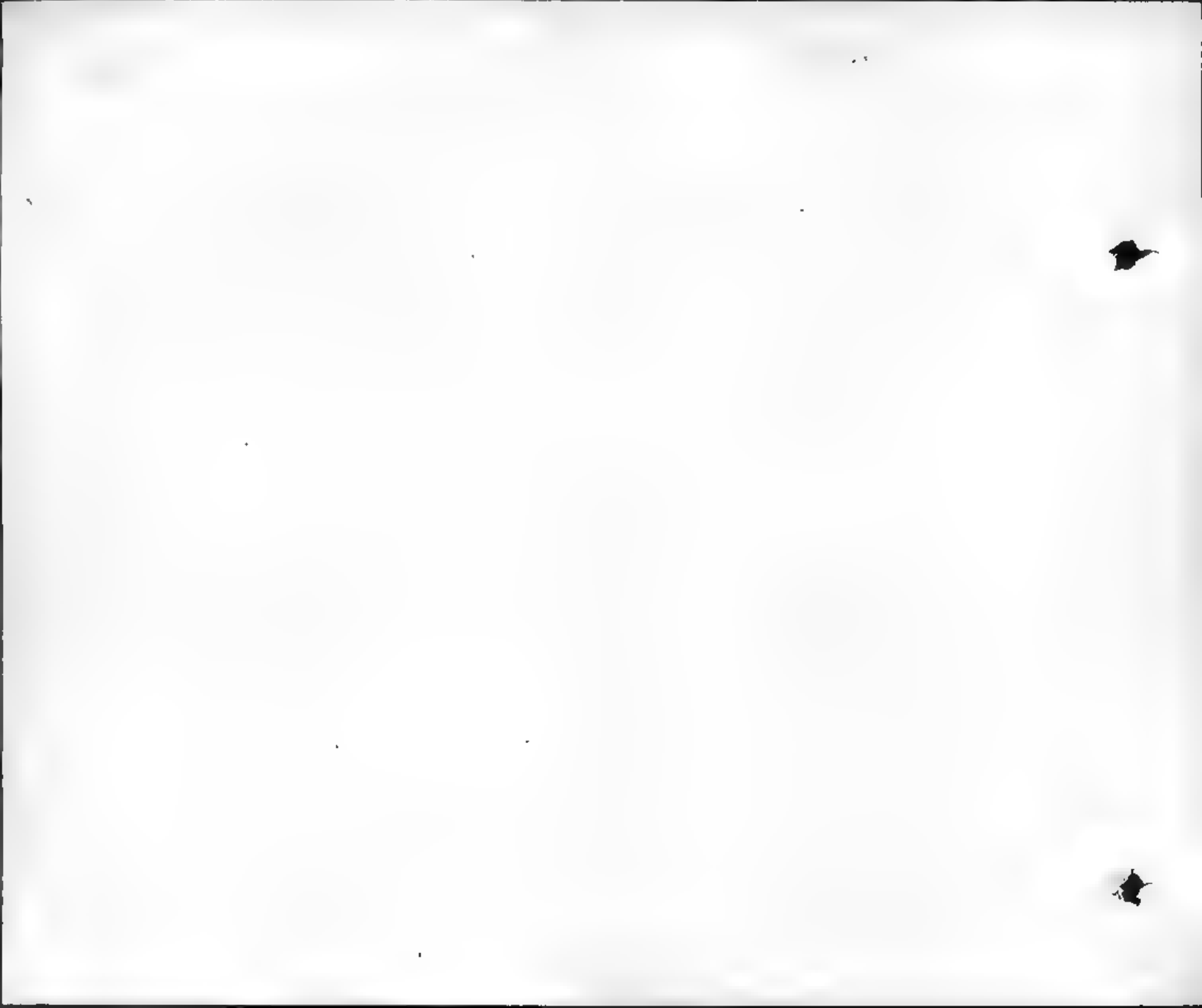
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12534

CERTIFICATE OF DEATH

Reg. Dist. 10-522

1 PLACE OF DEATH a. COUNTY <u>CECIL</u> b. CITY OR TOWN <u>EINTON</u> c. LENGTH OF STAY IN TB <u>2 WEEKS</u> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		2 USUAL RESIDENCE (Where deceased lived) 1 institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PERRYVILLE</u> d. STREET ADDRESS <u>1 BROAD STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Jennie</u> First Middle Last 4 DATE OF DEATH <u>11 5 1961</u> Month Day Year		5 SEX <u>F</u> 6 COLOR OR RACE <u>W</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>7/5/1911</u> 9 AGE (In years last birthday) <u>50</u> 10 UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a USUAL OCCUPATION: Give kind of work done during most of working life, even if retired <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u> 11 BIRTHPLACE (State or foreign country) <u>USA</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Willie Glasgow</u>		14 MOTHER'S MAIDEN NAME <u>Mary Hall</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <u>LOUIS LAKE</u> INFORMANT <u>PERRYVILLE, MD</u> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>EDEMA OF LUNGS & VISCERA</u> DUE TO <u>CEREBRAL VASCULAR ACCIDENT</u> Conditions, if any which gave rise to immediate cause (b), stating the underlying cause as (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>2 WEEKS</u> <u>10 YEARS</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY Home farm factory, street, office bldg. etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/23, 1961</u> to <u>11/5 1961</u> that I last saw the deceased alive on <u>11/5 1961</u> and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>201 E. MAIN ST PERRYVILLE, MD</u> DATE SIGNED <u>11/5/61</u> ACTUAL SIGNATURE <u>J. Randall Ross</u> M.D. PHYSICIAN'S NAME (Type) <u>J. RANDALL ROSS, M.D. EINTON, MD.</u>			
22a BURIAL CREMATION REMOVAL (Specify)		22b DATE THEREOF	
<u>BURIAL</u>		<u>11/7/61</u>	
22c NAME OF CEMETERY OR CREMATORY		22d LOCATION (City, town, or county) (State)	
<u>Woodland Cemetery</u>		<u>Ashland Virginia</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hickey</u> ADDRESS <u>EINTON, MD</u>		24a RECEIVED BY REGISTRAR <u>NOV 8 '61</u> 24b REGISTRAR'S SIGNATURE <u>C. H. & K. H.</u>	



12535

CERTIFICATE OF DEATH

Reg. Dis. 12523

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 21 Mos	
d. NAME OF HOSPITAL (If not in hospital give street address OR INSTITUTION) Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last CHARLES WILTING MARLOW SR.		4 DATE OF DEATH Month Day Year November 12, 1961	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 3, 1931
9 AGE (In years last birthday) yrs 30		10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) U.S. Post.		10b. KIND OF BUSINESS OR INDUSTRY Maritime	
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Luke Marlow		14 MOTHER'S MAIDEN NAME No Info.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16 SOCIAL SECURITY NO None	
INFORMANT Charles W. Marlow, Jr. Wilm. Del.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X DUE TO BILATERAL BRONCHOPNEUMONIA			
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO ACUTE BACTERIAL U.R.T.			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a			
Crown Heart Disease, Chronic Bronchitis			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 weeks? 1 week?	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/16, 1961, to 11/4, 1961 that I last saw the deceased alive on 11/6, 1961 and that death occurred at 8:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter Stavranis		DATE SIGNED 11/6/61	
PHYSICIAN'S NAME (Type) PETER STAVRANIS M.D.		ADDRESS (Street city or town, state) 1541 W. MAIN ELKTON, Md.	
22a B. & A. CREMATION, REMOVAL (Specify)	22b DATE THEREOF Nov. 7, 1961	22c NAME OF CEMETERY OR CREMATORY Gilpin Parson Memorial	22d LOCATION (City or town, or county) (State) Elkton, Md.
23 FUNERAL DIRECTOR'S SIGNATURE PIPER W. PINE M.D.		24a REC'D BY REGISTRAR DATE NOV 11 1961	
ADDRESS Longm Du Elkton, Md.		24b REGISTRAR'S SIGNATURE C. S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

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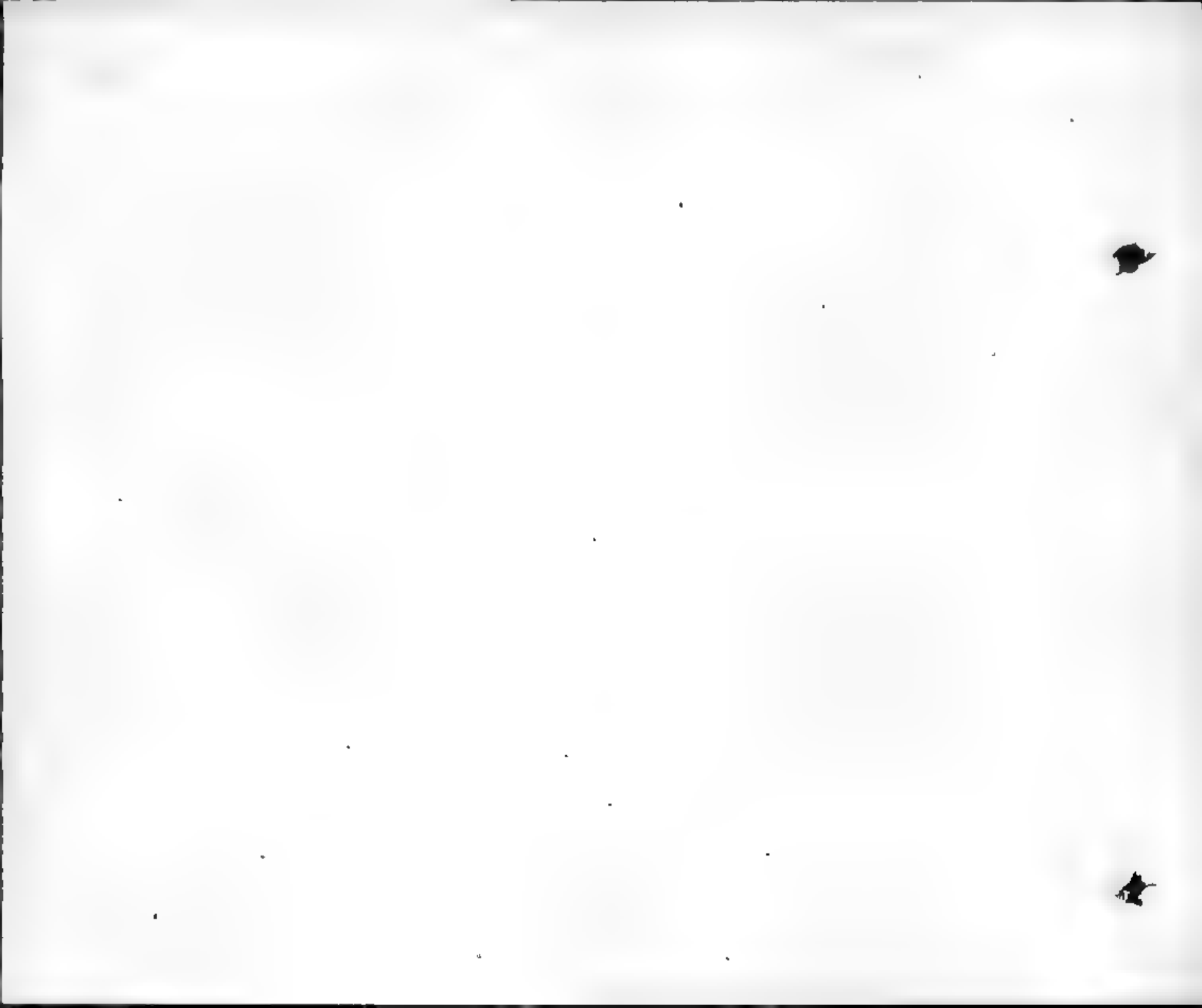
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 from birth certificate

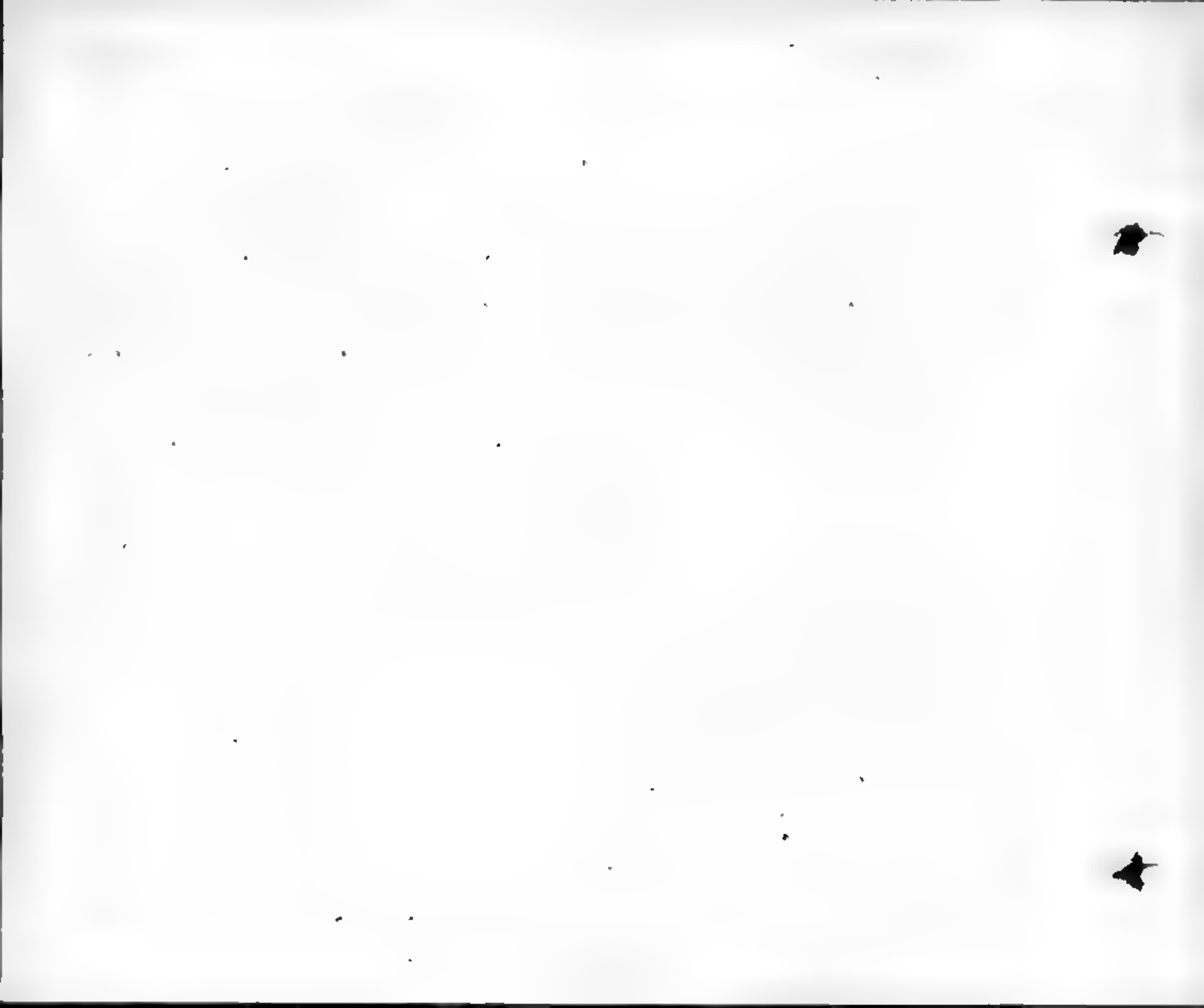
CERTIFICATE OF DEATH

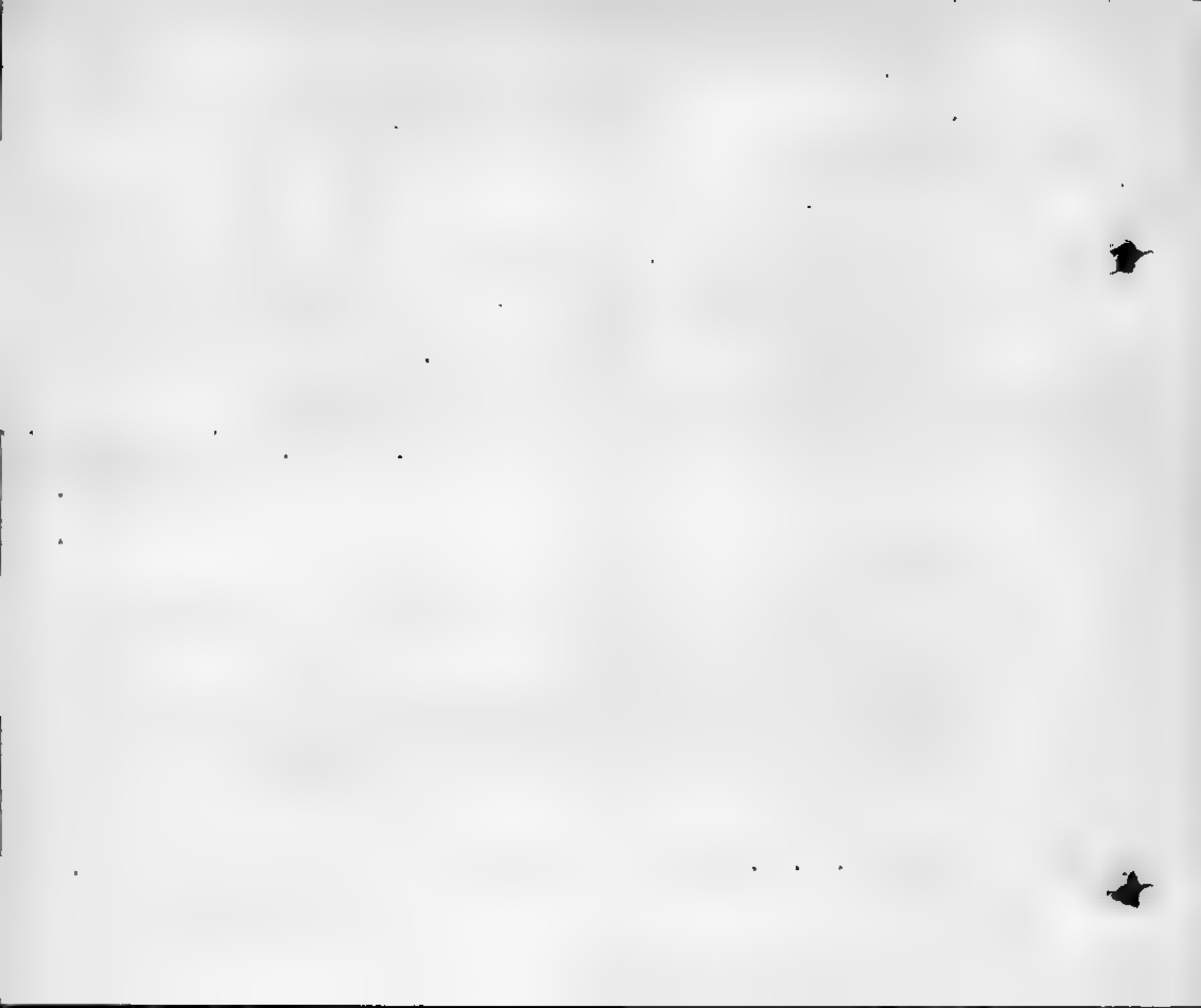
Reg. Dist. 18524

12536

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived if not at on Residence before admission) a. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) NEW Glasgow	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS XXXXXXXX Mobile Homes	
3 NAME OF DECEASED (Type or print) First Middle Last Jodi Lynne Mc Hair		4 DATE OF DEATH Month Day Year Nov. 14, 1961	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 13, 1961
9 AGE in years last birthday yrs		F UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXX		10b. KIND OF BUSINESS OR INDUSTRY XXXXXXXX	
11 BIRTHPLACE (State or foreign country) Elkton, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Joe Michael Mc Hair		14 MOTHER'S MAIDEN NAME Judith Ellen Van Keuren	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) no		16 SOCIAL SECURITY NO none	
17 INFORMANT Joe M. Mc Hair, Glasgow, Del.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Acute myocardial infarction (b) DUE TO Coronary aneurysm (c) DUE TO Subarachnoid hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 hours, 2 hours, ?	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from 11/13 1961 to 11/14 1961 that I last saw the deceased alive on 11/14 1961 and that death occurred at 4:35 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11/15/61 ACTUAL SIGNATURE Peter Stavakis, M.D. PHYSICIAN'S NAME (Type) Peter Stavakis, M.D.			
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 11-17-61	22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk.	22d. LOCATION (City, town, or county) (State) Nr. Elkton, Md.
23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald G. Pippin Elkton, Md.		24a. REC'D BY REGISTRAR DATE NOV 20 '61	24b. REGISTRAR'S SIGNATURE S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.





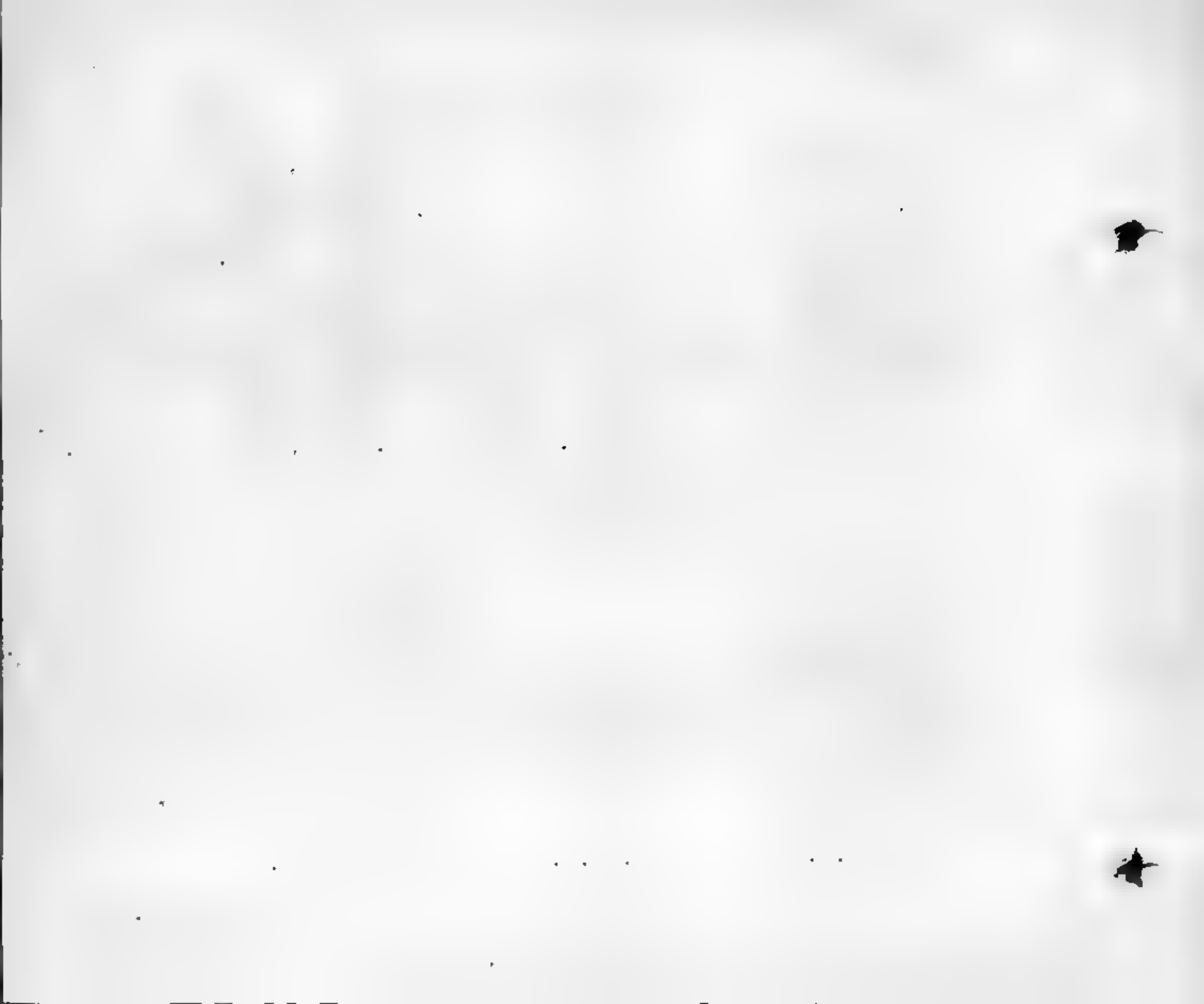
TO HOSPITAL OR ATTENDING PHYSICIAN- The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completed by filing in by the funeral director. After this certificate has been signed by the attending physician and completed by filing in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR- After this certificate has been signed by the attending physician and completed by filing in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

12538
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
12526

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE Where deceased lived if institution Residence before admission a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Port Deposit		c. CITY OR TOWN If outside corporate limits write RURAL and give nearest town Port Deposit, Rural	
d. NAME OF HOSPITAL OR INSTITUTION if not in hospital give street address Mt. Ararat Farms		d. STREET ADDRESS Mt. Ararat Farms	
3. NAME OF DECEASED Type of print First Middle Last Ann Celyne Mott		4. DATE OF DEATH Month Day Year Nov. 24 24/ 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1917	
9. AGE in years IF UNDER 1 YEAR IF UNDER 24 HRS. 44 yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life even if retired House Wife	
10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE County & State or foreign country Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert	
14. MOTHER'S MAIDEN NAME Ramson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 186-07-2407.		17. INFORMANT Frederick B. Mott, Port Deposit, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE 420.1 DUE TO Coronary Occlusion Generalized Arteriosclerosis Hypertension DUE TO DUE TO DUE TO		19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item 18 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc. 20f. City or town (County) (State)			
21. I certify that I (this hospital) attended the deceased from 6-21, 1961 to 11-24, 1961, and that death occurred at 2:28 P.M. from the causes and on the date stated above			
22a. SIGNATURE G.H. Richards Jr. M.D.		22b. DATE SIGNED 11/24/61	
22c. PHYSICIAN'S NAME (Type) G.H. Richards Jr. M.D.		22d. ADDRESS Port Deposit, Md.	
23a. BURIAL CREMATION Burial		23b. DATE THEREOF 11-27-1961	
23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City, town or county) Port Deposit, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson, Son		25a. REC'D BY REGISTRAR NOV 28 '61	
25b. REGISTRAR'S SIGNATURE William L. Knease		25c. ADDRESS Perryville, Md.	



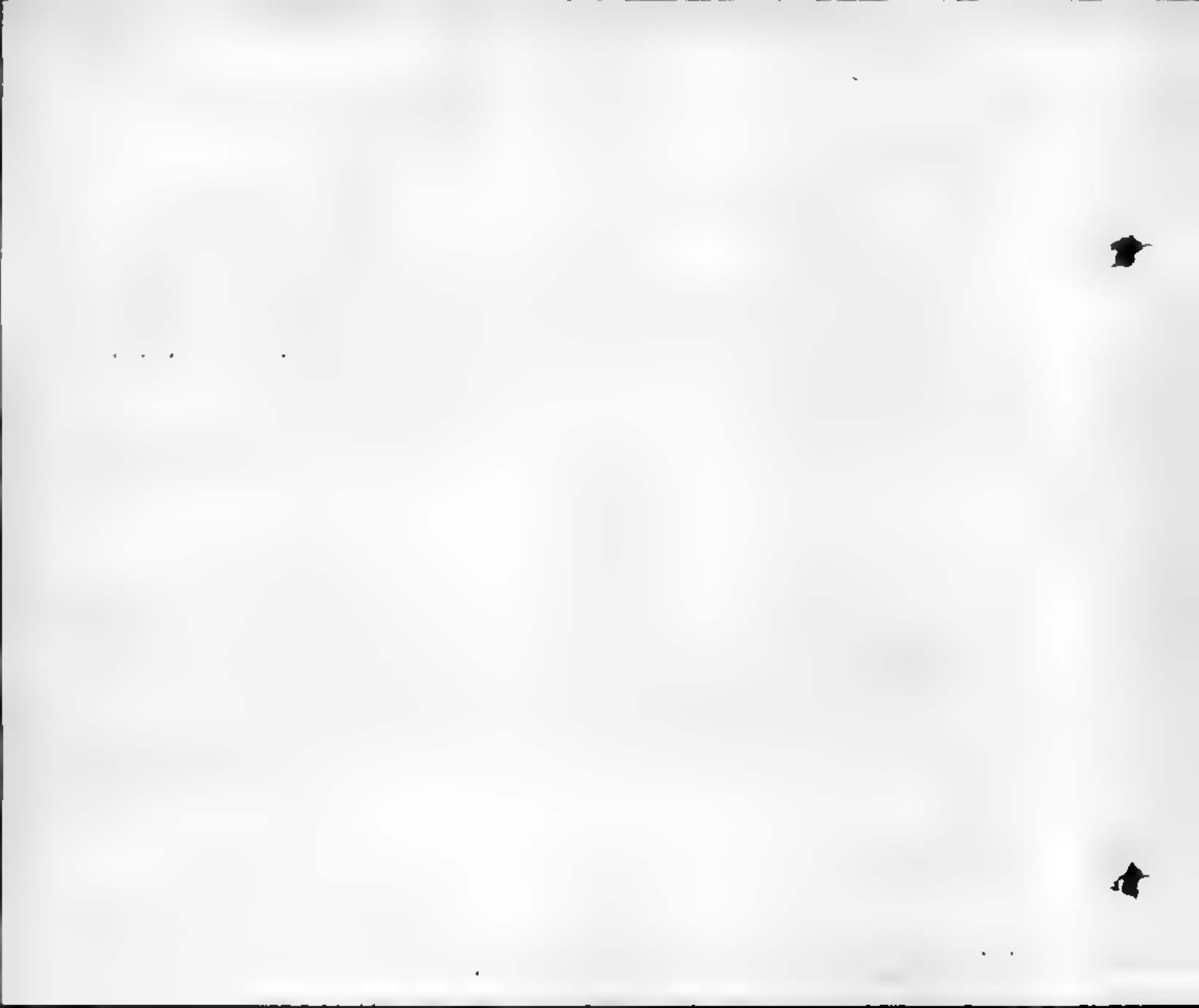
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12539

CERTIFICATE OF DEATH

Reg. Dist. 12527

1 PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>D.</u> Last <u>Muller</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/1899</u>
9. AGE (In years, last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>12</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Commercial Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Muller</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Muhe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>216 03 4612</u>	
17. INFORMANT <u>Robert C. Muller</u>		Address <u>44 Chippendale Circle,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>removal</u> <u>345X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>complications of multiple sclerosis</u> DUE TO (c) <u>12 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/15</u> , 19 <u>61</u> , to <u>11/14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11/13</u> , 19 <u>61</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor Jr</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>		DATE SIGNED <u>11/14/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>		24a. REC'D BY REGISTRAR <u>11/17/61</u>	
ADDRESS <u>4905 York Road, Baltimore 12, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. S. S.</u>	



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FOR STATE
HEALTH DEPT.

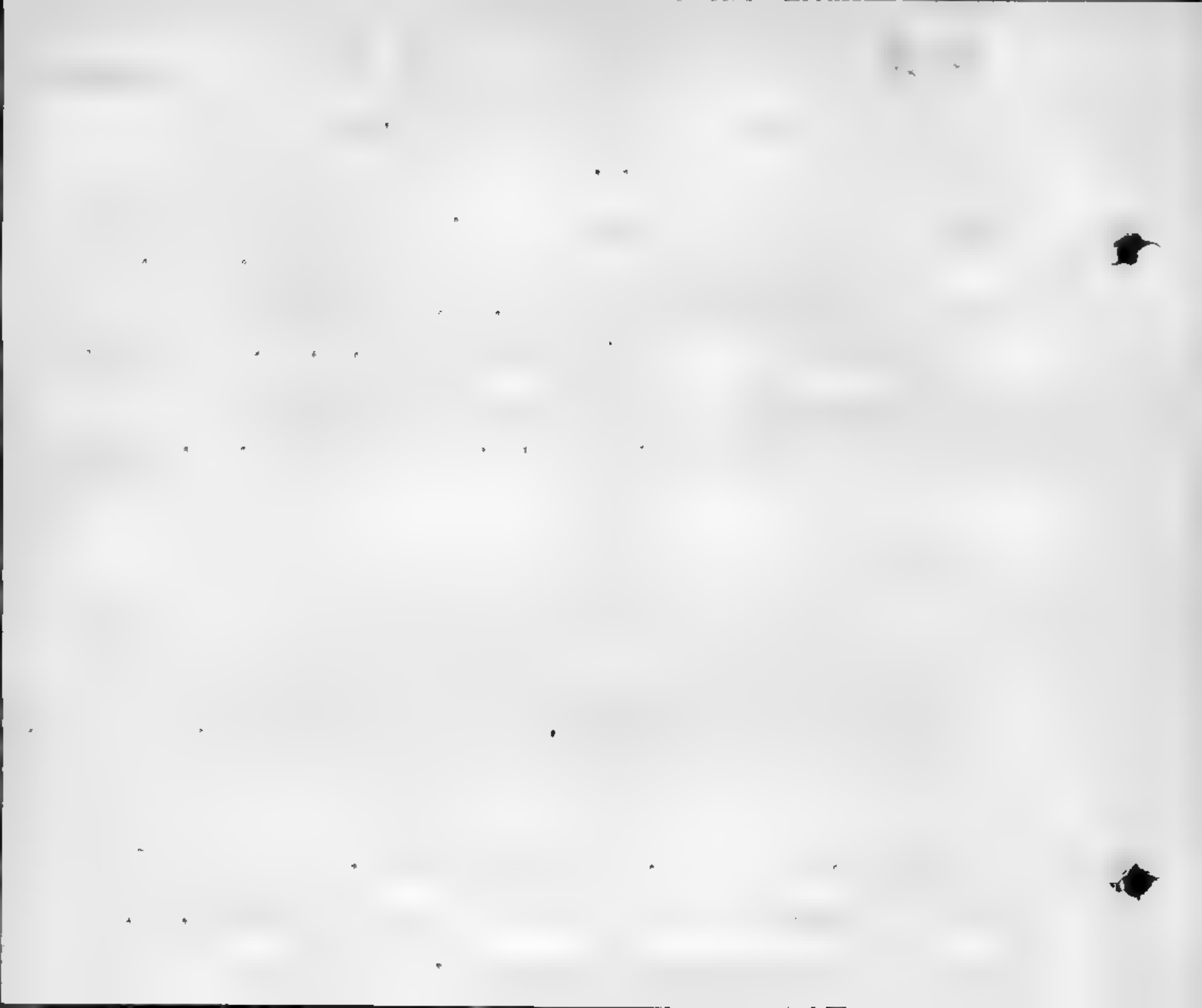
TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
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12540
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
12528

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived if Institution, Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
c. LENGTH OF STAY in th D.O.A.		d. STREET ADDRESS 324 W. Main Street,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KYLE MULLINS		4. DATE OF DEATH Nov. 4, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1938
9. AGE (In years last birthday) 22 yrs.		10. F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Plastic	
11. BIRTHPLACE State or foreign country Paynesville, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Harvey Mullins		14. MOTHER'S MAIDEN NAME Viola Blankenship	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) no		16. SOCIAL SECURITY NO. 220-34-6807	
17. INFORMANT Wm. H. Mullins, Elkton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractures Skull and neck DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Car turned over after cutting off of telephone Pole	
20c. TIME OF INJURY Month, Day, Year 3:00 P.M. 11/4/61		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) White Not White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Rt. 274 North East R.D. Cecil Co., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Dodson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-8-61	
22c. NAME OF CEMETERY OR CREMATORY Vance Cemetery		22d. LOCATION (City, town, or county) (State) Paynesville, W. Va.	
23. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME, 1000 N. 1st St., Elkton, Md.		24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Nov 9 '61	

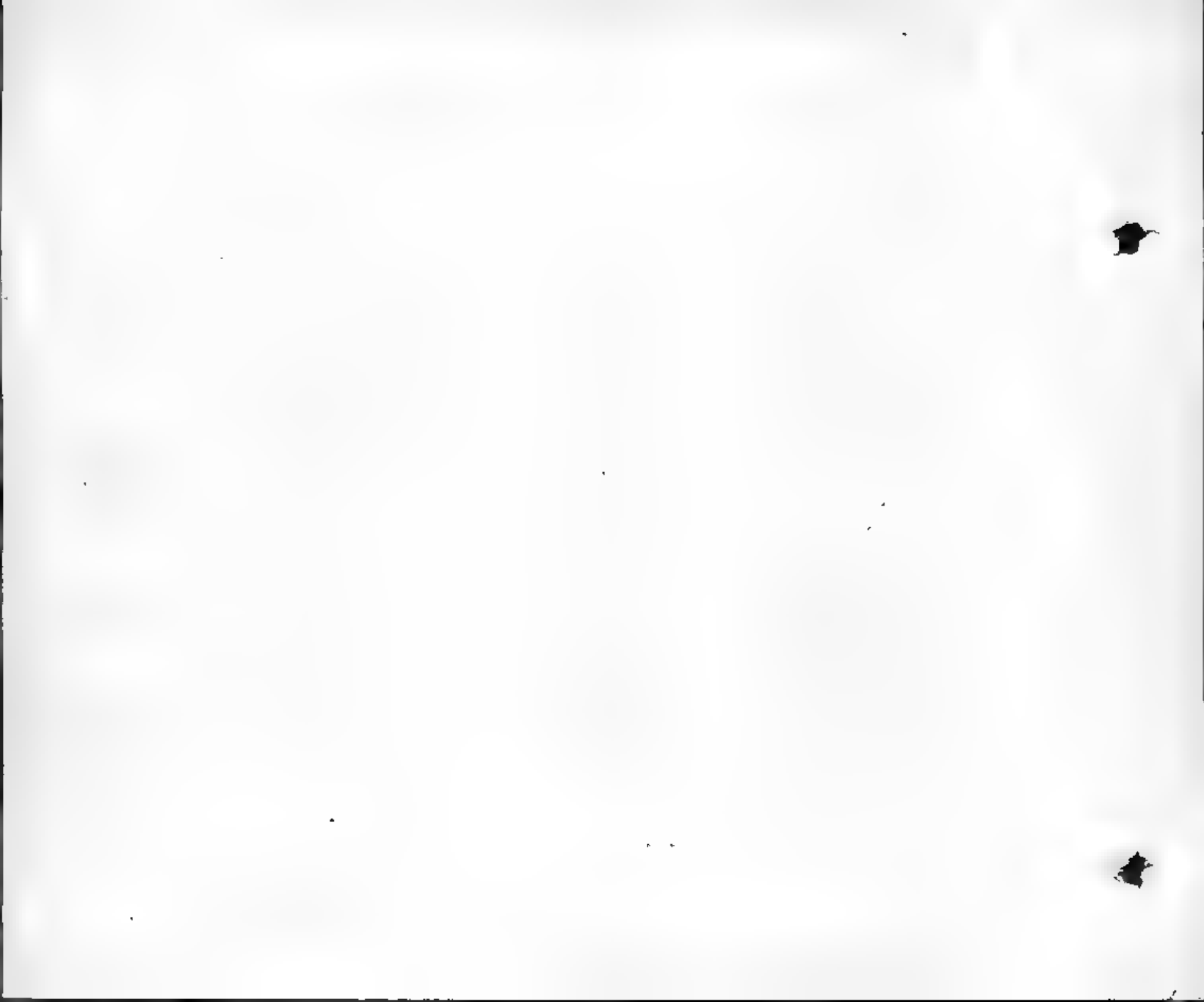
DATE SIGNED
11-5-61



Reg Dis No 12529

12541

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bohemia Manor		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If not usual, Residence before admission, a. STATE Md.		b. COUNTY Cecil	
d. NAME OF HOSPITAL, (if not in hospital, give street address) OR INSTITUTION Bohemia Manor, near Chesapeake City,				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bonemia Manor, near Chesapeake City				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edna		First		Middle Nuble		Last		4. DATE OF DEATH Month Nov. Day 27. Year 1961	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1876		9. AGE In years (last birthday) 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Minor Washington				14. MOTHER'S MAIDEN NAME Kate-?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO. 213-01-1164		INFORMANT Address Lola Nuble, Bohemia Manor, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia with cerebral thrombosis									
446X DUE TO (b) Neprosclerosis									
Conditions if any which gave rise to immediate cause (c), stating the underlying cause last DUE TO (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a senility									
20a. ACCIDENT WAS UNOCCURRED <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)							
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY Home farm, factory, street, office bldg, etc.		20f. (City or town)		County (State)	
21. I certify that I attended the deceased from Nov 25 , 19 61 to Nov 27 , 19 61 , that I last saw the deceased alive on 27 Nov , 19 61 , and that death occurred at 2AM M. from the causes and on the date stated above									
ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 28 Nov 61									
ACTUAL SIGNATURE Wallace Obenshain M.D.									
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.									
22a. BURIAL CREMATION, REMOVAL, (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
Burial		12/2/61		Ebenezer Cem.		Bohemia Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Edw. A. Bell				ADDRESS 309 Poplar St. Wilm.		24a. RECEIVED BY REGISTRAR DATE NOV 30 '61		24b. REGISTRAR'S SIGNATURE	



1
FOR STATE
HEALTH DEPT.

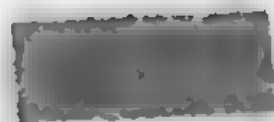
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

12542
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12530
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Rt. 274</u>				c. LENGTH OF STAY in lb <u>Instant</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North East, Md.</u>				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
3. NAME OF DECEASED (Type or print) <u>William Riley Payne</u>				d. STREET ADDRESS <u>214 E. Main Street,</u>			
5. SEX <u>Male</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>June 12, 1936</u>			
9. AGE (in years) last birthday <u>25</u> yrs.				10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>			
11. BIRTHPLACE (State or foreign country) <u>Paynesville, W. Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Irvin Payne</u>				14. MOTHER'S MAIDEN NAME <u>Rhoda Mullins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>U.S. ARMY</u>				16. SOCIAL SECURITY NO. <u>236-54-6684</u>			
17. INFORMANT <u>Mrs. Ella Jane Payne, Elkton, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY a. IMMEDIATE CAUSE (a) <u>Broken Neck and crushed body</u> b. <u>NO</u> c. <u>NO</u> Cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Car turned over after cutting off Telephone Pole</u>			
20c. TIME OF INJURY Month Day Year <u>3:00 P.M. 11-4-61</u>				20d. INJURY OCCURRED - 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Rt. 274 North East R.D. Cecil Co., Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R.C. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. DODSON, MD.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>11-8-61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Payne Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Paynesville, W. Va.</u>			
23. FUNERAL DIRECTOR <u>HIPPIN FETTERAL HOME</u>				24a. REC'D BY REGISTRAR <u>NOV 9 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>John S. Thomas</u>				DATE SIGNED <u>11-5-61</u>			

HIPPIN FETTERAL HOME, 1000 N. 1st St., Elkton, Md.



12543

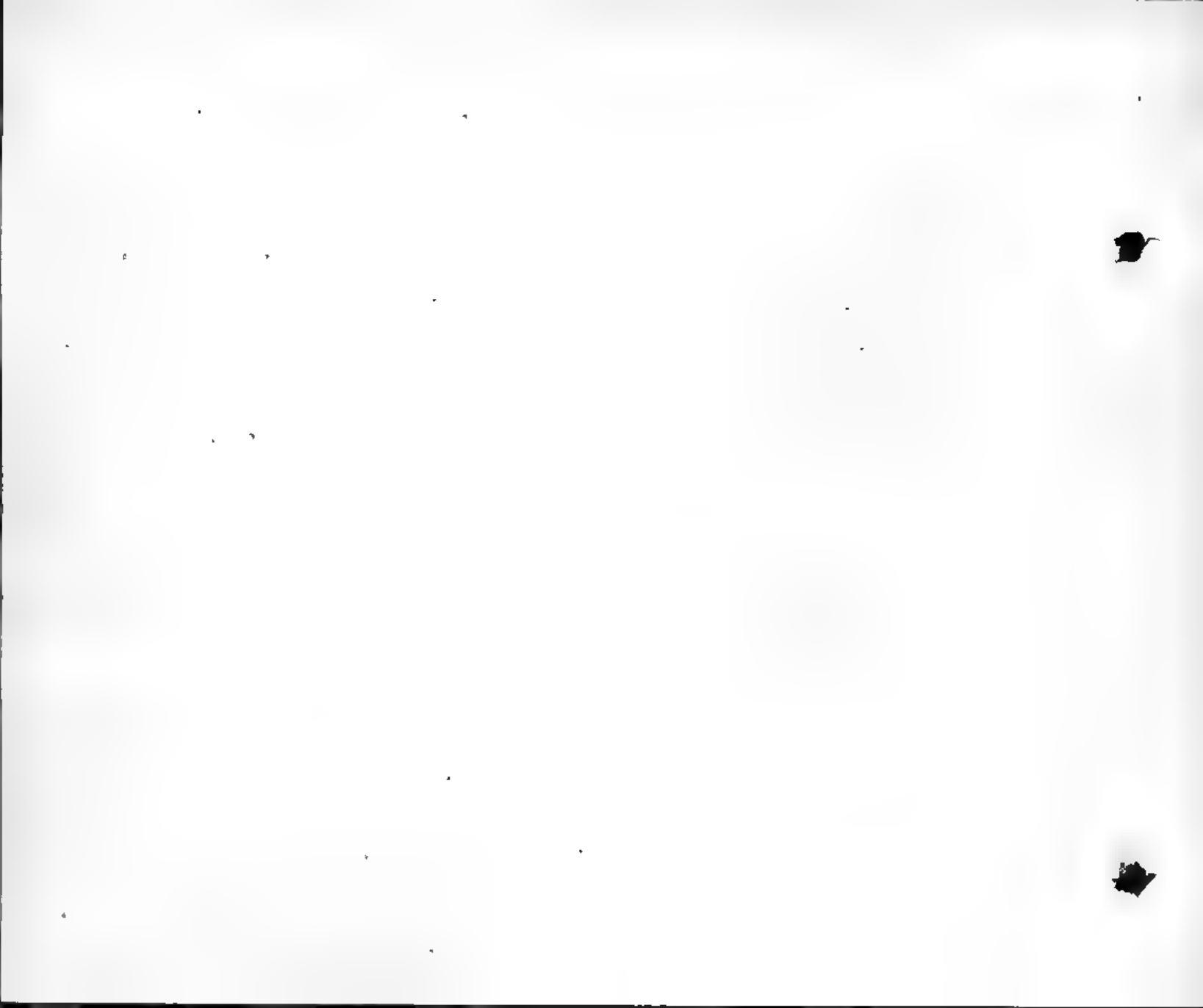
CERTIFICATE OF DEATH

Reg. Dist. 12531

1 PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN lb <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) <u>Union Hospital</u>		e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Chesapeake City</u>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type as printed) First <u>MARTHA</u> Middle <u>CLINTON</u> Last <u>PENSEL</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1879</u>
9. AGE In years (last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11a. USUAL OCCUPATION Give kind of work done during most of working life (even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	
11c. BIRTHPLACE (State or foreign country) <u>Warwick, Md.</u>		12. COUNTRY OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clinton Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Caldwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
INFORMANT <u>Henry J. PenseL, Chesapeake City, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u>			
420.1 DUE TO <u>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</u>			
10 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u>a.m.</u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that attended the deceased from <u>Oct. 1940</u> to <u>Nov. 19, 1961</u> , that I last saw the deceased alive on <u>Nov. 19, 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above			
ADDRESS (Street, city or town, state) <u>CHESAPEAKE CITY, MD.</u> DATE SIGNED <u>11/21/61</u>			
ACTUAL SIGNATURE <u>Henry J. Davis MD</u>			
PHYSICIAN'S NAME (Type) <u>HENRY J. DAVIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-22-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town or county, (State) <u>Chesapeake City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PI. IN FUNERAL HOME</u>		24a. REG. BY REGISTRAR <u>NOV 22 1961</u>	
ADDRESS <u>Elkton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.



Reg. Dist. No. **12532**

12544

1 PLACE OF BIRTH a. COUNTY Cecil		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN TB 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First William Middle H. Last Pyle		4 DATE OF DEATH November 18 1961		5 SEX Male	
6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH April 19, 1983	
9 AGE in years last birthday 78 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY Fish	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME William C. Pyle	
14 MOTHER'S MAIDEN NAME Agnes Potridge		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of service) No		16. SOCIAL SECURITY NO None	
17 INFORMANT George Pyle		18 ADDRESS Chesapeake City, Md.		19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions if any which gave rise to immediate cause (a), stating the underlying cause last (b) M. Senere T. Thompson (c) Coronary Arteriosclerosis	
20 INTERVAL BETWEEN ONSET AND DEATH 3 days		21 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I PART II		22 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)		24 TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	
25 INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		26 PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)		27 CITY OR TOWN (County) (State)	
28 I certify that I attended the deceased from 13 Nov. 1961 to 18 Nov 1961, that I last saw the deceased alive on 18 Nov. 1961, and that death occurred at _____ M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 2/11/62	
ACTUAL SIGNATURE Wallace Obenshain M.D.		PHYSICIAN'S NAME (Type) Wallace Obenshain		Cecilton, Md.	
29a. BURIAL OR CREMATION REMOVAL (Specify) Burial		29b. DATE THEREOF Nov. 22, 1961		29c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	
29d. LOCATION (City, town, or county) Chesapeake City, Md.		30a. REC'D BY REGISTRAR DATE NOV 22 '61		30b. REGISTRAR'S SIGNATURE James L. Fries	
31 FUNERAL DIRECTOR'S SIGNATURE Dorothy R. Elton, Md.		32 ADDRESS Elkton, Md.		33 REC'D BY REGISTRAR DATE NOV 22 '61	
34 REGISTRAR'S SIGNATURE James L. Fries		35 ADDRESS Elkton, Md.		36 REC'D BY REGISTRAR DATE NOV 22 '61	



4252
Ref. Diff. No.

MEDICAL CERTIFICATION

Page 4

VS AIS (4)
15M 9/55



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12534

1. PLACE OF DEATH
a. COUNTY CECIL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Ho spital

2. USUAL RESIDENCE Where deceased lived, if institution (Residence before admission)
a. STATE MD. b. COUNTY CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN
d. STREET ADDRESS RISING SUN

3. NAME OF DECEASED (Type or print) First Middle Last
WALTER HERBERT REYNOLDS

4. DATE OF DEATH Month Day Year
11/ 22/ 1961

5. SEX M. 6. COLOR OR RACE W. 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH
1/ 9/ 1939 9. AGE In years (last birthday) 22 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired Machine Operator Cable Plant Md.
10b. KIND OF BUSINESS OR INDUSTRY MD. 11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Horace J. Reynolds 14. MOTHER'S MAIDEN NAME Ruby Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No 16. SOCIAL SECURITY NO 219 36 0871 17. INFORMANT Paula E. Reynolds Rising Sun, Md. Address

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture of right fibula and Tibia compounded
823 x DUE TO Fracture of neck abrasion both legs left side of
Conditions, if any which gave rise to immediate cause (b) forehead laceration of scalp 2 1/2 in long and 1 1/4 in long.
(c), stating the underlying cause last DUE TO

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
Car wrecked and he was hit a tree.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
Car wrecked and he was hit a tree.

20c. TIME OF INJURY Month Day Year Hour Min. 11 22 61
20d. INJURY OCCURRED at work ☐ Not at work ☒ 20e. PLACE OF INJURY Home, farm, factory, store, office, bldg, etc.) Route 145 Elkton R.D. Cecil Md.

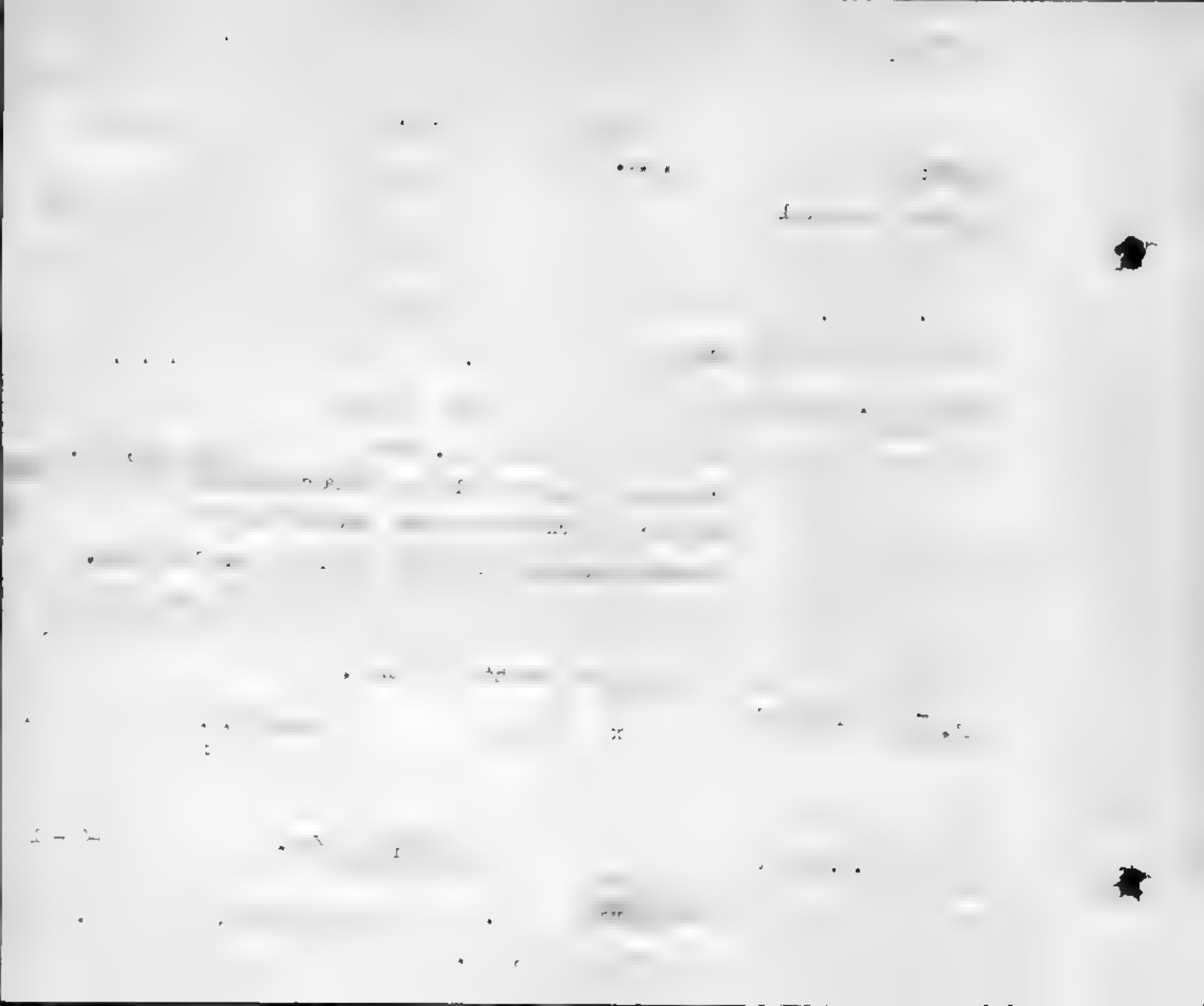
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE R.C. Dodson M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME Type R.C. Dodson ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER Rising Sun Md. DATE SIGNED 11-23-61
Address (Street city town or county)

22a. BURIAL CREMATION 22b. DATE THEREOF 11/26/ 61 22c. NAME OF CEMETERY OR CREMATORY Brookview Cem. 22d. LOCATION (City town, or country) Rising Sun Md.

23. FUNERAL DIRECTOR Norman E. McMullen ADDRESS Rising Sun, Md. 24a. REC'D BY REGISTRAR Nov 27 61 24b. REGISTRAR'S SIGNATURE James L. Prange

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it may be executed at a later date. Execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be kept for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



<p>1. PLACE OF DEATH a. COUNTY <u>CECIL</u></p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Perryville</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address) <u>V.A.H., Perry Point, Md.</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u></p> <p>d. STREET ADDRESS <u>2426 -N Street, N.W.</u></p>	
<p>3. NAME OF DECEASED (Type or print) <u>Fructuoso RIVERA</u></p> <p>5. SEX <u>Male</u></p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Machine Operator</u></p> <p>13. FATHER'S NAME <u>Bicente Rivera</u></p>		<p>6. DATE OF DEATH <u>Nov. 10, 1961</u></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1-21-24</u></p> <p>9. AGE (in years last birthday) <u>37</u> yrs.</p> <p>11. BIRTHPLACE (State or foreign country) <u>Asherton, Texas</u></p> <p>14. MOTHER'S MAIDEN NAME <u>Marie Mendez</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Korean</u></p> <p>16. SOCIAL SECURITY NO. <u>457-44-7890</u></p>		<p>17. INFORMANT <u>V.A. Hospital Records-Perry Point, Md.</u></p> <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation</u> <u>929.9</u> DUE TO Conditions, if any which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO <u>Accidental Drowning</u> (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Diabetes Mellitus</u></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></p> <p>20c. TIME OF INJURY Month Day Year Hour a.m. <u>---</u> p.m. <u>---</u> 19<u>61</u></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of Item 18) <u>Caught foot in board over ditch & fell and unable to raise head out of water</u></p> <p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u></p> <p>20f. (City or town) <u>---</u> County <u>---</u> (State) <u>---</u></p>	
<p>21. I certify that <u>---</u> took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE <u>F.S. DODSON</u></p> <p>EXAMINER'S NAME (Type) <u>F.S. Dodson</u></p>		<p>CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 11/10/61 DATE SIGNED</p> <p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p> <p>Address (Street, city, town, or county) <u>Rising Sun, Md.</u></p>	
<p>22b. DATE THEREOF <u>11/11/61</u></p> <p>22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u></p> <p>22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u></p>		<p>24a. REC'D BY REGISTRAR <u>NOV 20 1961</u></p> <p>24b. REGISTRAR'S SIGNATURE <u>Anthony S. Harris</u></p>	

MEDICAL CERTIFICATION

ACTUAL
SIGNATURE **F. S. DODSON**

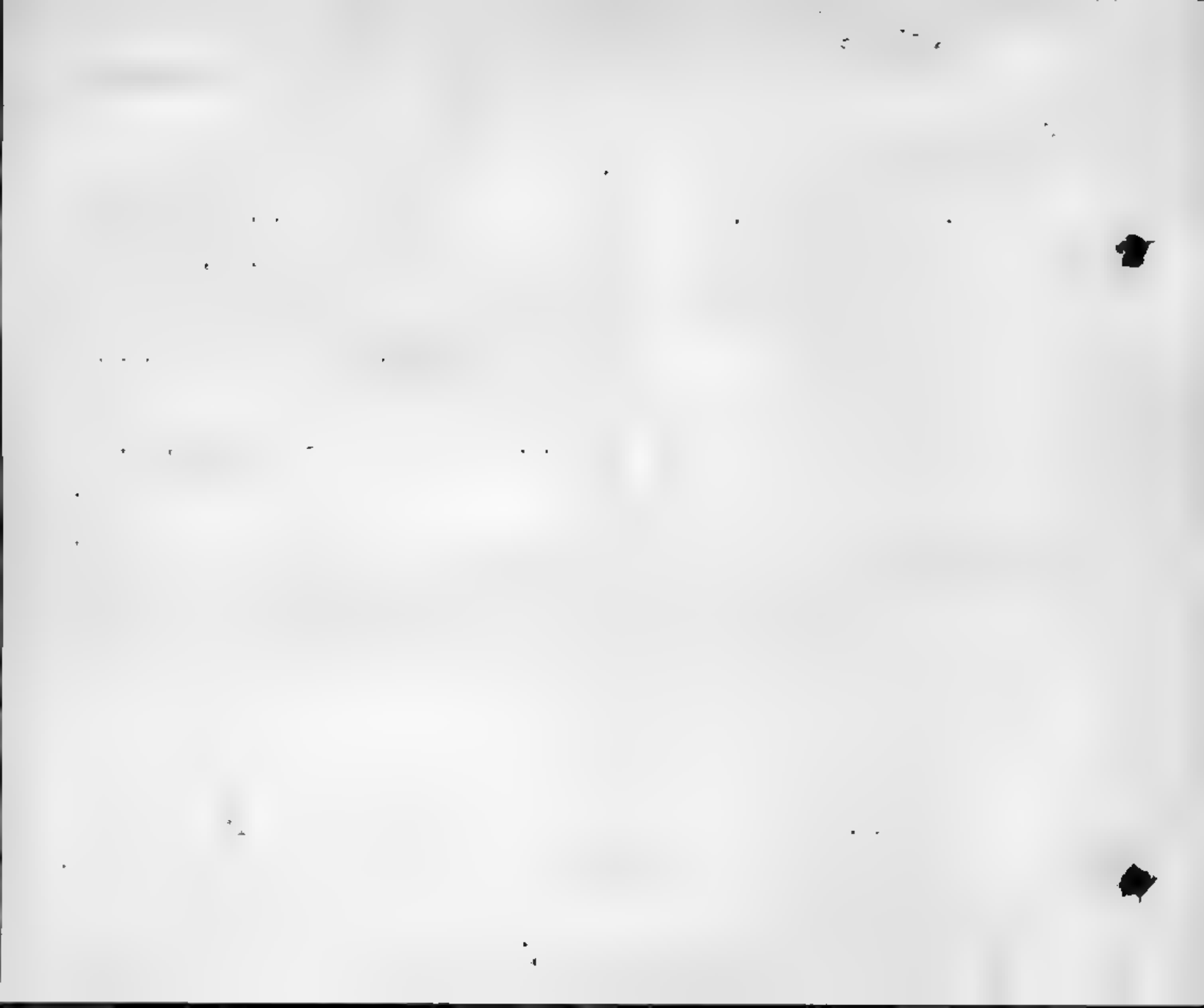
EXAMINER'S
NAME Type *[Signature]*

22a. BURIAL CREMATION REMOVAL (Specify) Removal
22b. DATE THEREOF 11/11/61
23. FUNERAL DIRECTOR Jennings & Son, H

CHIEF MEDICAL EXAMINER ☒ 11/10/61 DATE SIGNED
M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county) Rising Sun, Md.

LABORATORY	22d. LOCATION (City town or country)	State
ational	Baltimore, Md.	
24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
DATE NOV 20 '61	<i>Anthony J. Hanna</i>	

VS. A15ME
\$M 9 40



12548

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

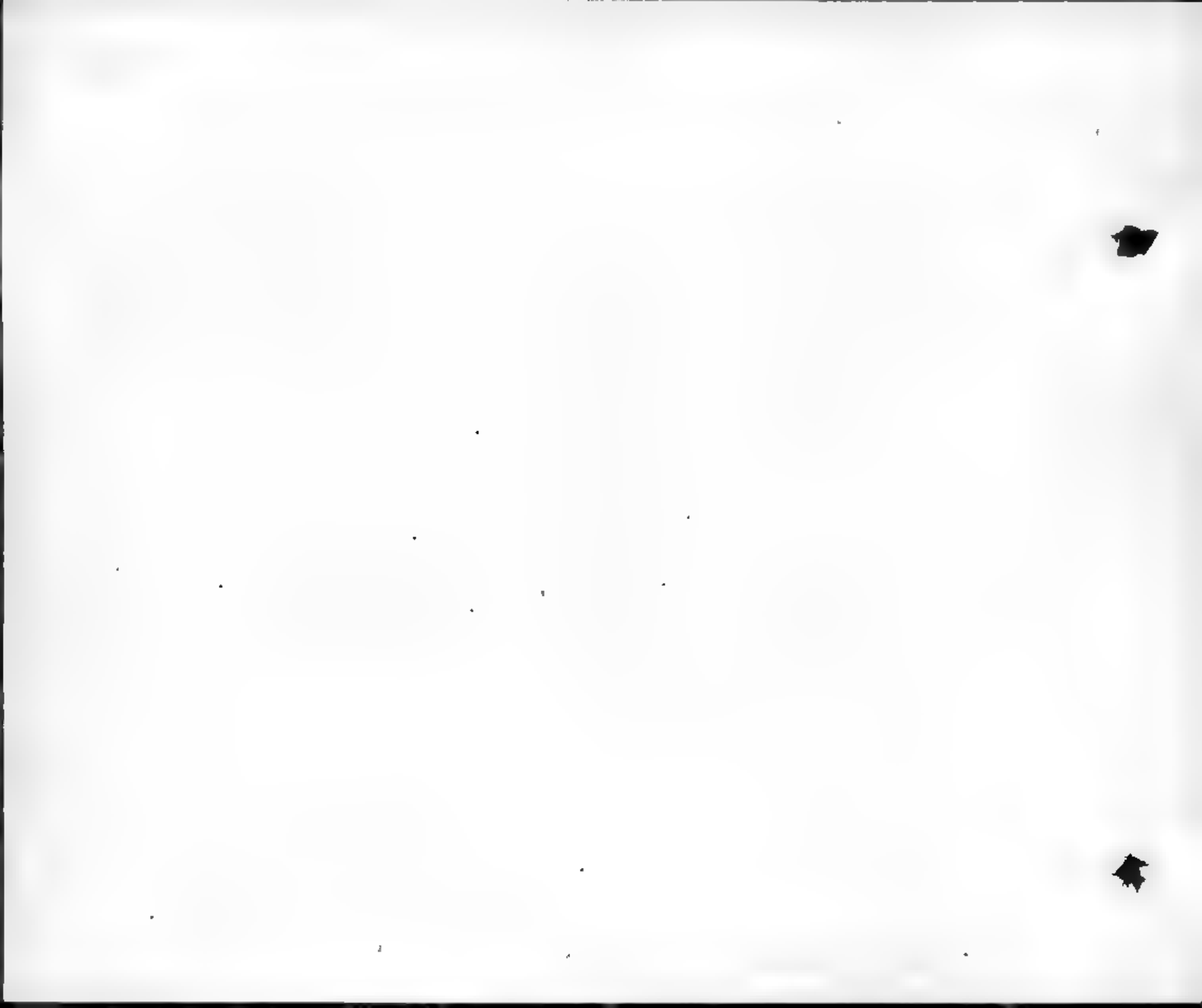
CERTIFICATE OF DEATH

Reg 10536

1 PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2 USUAL RESIDENCE Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union</u>		d. STREET ADDRESS <u>1 RODES</u>	
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>S</u> Last <u>ROARK</u>		4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/6/01</u>
9. AGE (in years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u> Hours <u>2</u> Min <u>19</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life (even if retired) <u>General Plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William M. Roark</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>091-01-8702</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>502.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Chronic pulmonary emphysema</u> DUE TO <u>8-10 years</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Pulmonary infection bilateral in 1954-1958</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 weeks</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month. Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from <u>1954</u> to <u>11/2</u> , 1961 that I last saw the deceased alive on <u>11/2</u> , 1961, and that death occurred at <u>10:25 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter Stank</u> M.D.		ADDRESS (Street only or town, state) <u>134 W MAIN</u>	
PHYSICIAN'S NAME (Type) <u>PETER STANK M.D.</u>		LOCATION (City, town, or county) (State) <u>ELKTON MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/6/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Park, Elkton, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Karl E. Hicks</u>		ADDRESS <u>Elkton, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 8 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 72 hours after death.

may be returned by the hospital or attending physician to the funeral director. After the certificate has been signed by the attending physician and completely filled out, the funeral director should detach the certificate from the carbon copy and return it to the funeral director. The funeral director should then detach the certificate from the carbon copy and return it to the funeral director. The funeral director should then detach the certificate from the carbon copy and return it to the funeral director.



12549

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12537

1 PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>	
c. LENGTH OF STAY IN 1b <i>2 mo.</i>		d. STREET ADDRESS <i>Elk Mills</i>	
d. NAME OF HOSPITAL OR INSTITUTION <i>Union Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Winfield Schly Simpser</i>		4 DATE OF DEATH Month <i>11</i> Day <i>19</i> Year <i>1961</i>	
5 SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Dec. 25 1901</i>
9 AGE (In years, last birthday) <i>59</i> ya		10 UNDER 24 HRS Months <i>11</i> Days <i>19</i> Hours <i>19</i> Min <i>19</i>	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Paper Mill Maryland</i>	
11 BIRTHPLACE (State or foreign country) <i>D. S. A.</i>		12 CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13 FATHER'S NAME <i>George Simpser</i>		14 MOTHER'S MAIDEN NAME <i>Annie Seth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>221-07-9008</i>	
17 INFORMANT <i>Miss Hanna Simpser</i>		Address <i>Elk Mills Md.</i>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Tuberculous</i>			
581 <i>1</i> DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
(b) DUE TO			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
<i>Chronic pyelonephritis</i>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>August 1961</i> to <i>11-19</i> , 1961 that (I) (we) last saw the deceased alive on <i>11-19</i> , 1961 and that death occurred at <i>2 A.M.</i> from the causes and on the date stated above			
22a. SIGNATURE <i>William D. Johnson</i> M.D.		22b. DATE SIGNED <i>11-20-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>William D. Johnson (MD)</i>		22d. ADDRESS <i>123 Singlerly Ave Elkton Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11-24-61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cherry Hill Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Cherry Hill Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas E. McNeill</i>		25a. REC'D BY REGISTRAR <i>Rising Sun, Md.</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles S. Harris</i>		DATE <i>NOV 22 '61</i>	

(M)



CERTIFICATE OF DEATH

Reg. Dist. 12538

12550

M

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived if not in residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>North East</u>		c. LENGTH OF STAY IN TB <u>27 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Regina</u> Middle <u>M</u> Last <u>Spann</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1867</u>
9. AGE (in years last birthday) <u>4</u> yrs		10. F UNDER 1 YEAR: Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas McEanis</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hennessey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MISS MARGARET SPANN, North East, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1 Cardio-vascular failure</u> DUE TO <u>Bilateral pneumonia</u> G.A.S., A.S.C.V.D. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Senility, Cerebral Art. Sclerosis, Gen. Chr. Rh. Arthrit.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>3 days</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>11</u> Day <u>3</u> Year <u>1961</u> Hour <u>8:20 AM</u> Min <u>4</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-3-1961</u> to <u>11-4-1961</u> and that death occurred at <u>8:20 AM</u> from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <u>Luis M. Guza</u> M.D.		ADDRESS (Street, city or town, state) <u>Cecil Ave., North East, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Luis M. Guza, M.D.</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-7-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception</u>		22d. LOCATION (City, town or county) (State) <u>Elkton Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Grant</u> ADDRESS <u>North East, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 9 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Carlton L. Thomas</u>	

Page 4
The low requires that the death certificate be executed within 24 hours after death by the funeral director or by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with a 72 hour delay after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO VITAL REGISTRAR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12551

12539

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 2mo. 21days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last LESLIE (NMI) VICKROY			4. DATE OF DEATH Month Day Year November 22 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-91		9. AGE (In years last birthday) 69 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (retired)		10b. KIND OF BUSINESS OR INDUSTRY Chemical		11. BIRTHPLACE (Country & State, or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Not available		
14. MOTHER'S MAIDEN NAME Rose Kirby			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-I None		
16. SOCIAL SECURITY NO. None			17. INFORMANT Hospital Records, VAH, Perry Point, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 162-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Bronchogenic carcinoma right upper lobe of lung unknown DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6-7 days					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that XXXXXX attended the deceased from Sept. 1, 1961 to Nov. 22, 1961 and that death occurred 8:20 AM from the causes and on the date stated above.					
22a. SIGNATURE A. L. Mooney M.D.			22b. DATE SIGNED 11-22-61		
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/25/61		23c. NAME OF CEMETERY OR CREMATORY Still Pond	
23d. LOCATION (City, town or county) Still Pond, Md.		23e. (State)		23f. (County)	
24. FUNERAL DIRECTOR'S SIGNATURE Kennedy Funeral Home, Still Pond, Md.			25a. REC'D BY REGISTRAR DATE NOV 27 '61		
25b. REGISTRAR'S SIGNATURE Arthur S. Klaus			25c. (State)		

15551

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may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12552

CERTIFICATE OF DEATH

Reg. Dist. No. 12540

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eikton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eikton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union-Eikton, MD.</u>				d. STREET ADDRESS <u>189 Williamsworth Manor</u>			
3. NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>Taylor</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/5/1893</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAPER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mason</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>214-01-0389</u>		INFORMANT <u>DAVID K. WILLIAMS</u> Address <u>CHERRY HILL, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IRREVERSIBLE SHOCK & EMBOLI OF MYOCARDIUM</u> <u>219X</u> DUE TO (b) <u>PERI-NEPHROTIC ABSCESSES</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>TUMOR RIGHT KIDNEY</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EMBOLISM; MYOCARDIAL STENOSIS; DIABETES MELLITUS</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>11/12</u> 19 <u>61</u> , to <u>11/17</u> 19 <u>61</u> that I last saw the deceased alive on <u>11/17</u> 19 <u>61</u> and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Randall Ross</u> M.D. <u>201 E. Main St</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>11/17/61</u>			
PHYSICIAN'S NAME (Type) <u>J. RANDALL ROSS M.D. Eikton, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/20/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WEST NOTTINGHAM</u>		22d. LOCATION (City, town, or county) (State) <u>WEST NOTTINGHAM, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>Dock M 226 Eikton, MD.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>NOV 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>C. King</u>	

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